**AUTOMOBILE ACCIDENT REPORT**

Name:_____Date:_____

**Accident Information**-Date of Accident:_____Time of Accident:_____

Location:_____

Road Conditions: Dry____ Damp____ Wet____ Snow____ Ice____ Other_____

Description of Accident:_____

_____

**History of Injury**:

Were you: Driver____ Passenger ____ Driver Rear____ Passenger Rear____

Auto Struck: Driver Front____ Driver Rear____ Passenger Front____ Passenger Rear____

At Impact: Turning Left____ Turning Right____ Moving____(mph_____) Stopped____

Was your vehicle thrust forward: Yes____ No____ if yes how far?_____

Did the impact of the collision force your vehicle to impact another vehicle or object:_____

If so explain:_____

Model of vehicle: Yours_____ Other_____

Traffic citation issued to: You____ Other Driver____

Was police report made: Yes____ No____

Damage to your vehicle $_____ Damage to other vehicle: None Minimal Moderate Major

Did you see the accident coming: Yes____ No____

Were your brakes applied: Yes____ No____

Were seatbelts on: Yes____ No____

Were head restraints in use: Yes____ No____

Was seat adjustment altered from impact: Yes____ No____

Did air bags deploy: Yes____ No____

Were you thrown from your seat: Yes____ No____

Were hat or glasses still on after crash: Yes____ No____ n/a____

Were you thrown against any part of the car: Yes____ No____

What parts:_____

Upon impact was there a 'blinding' or 'explosion' sensation in you head: Yes____ No____

Were you able to get out of car and walk: Yes____ No____

Did you lose consciousness: Yes____ No____ If yes how long?_____

Could you move all parts of your body: Yes____ No____

**Injury treatment and follow-up**:

Was an ambulance called: Yes____ No____

Did you go to a hospital: Yes____ No____ If yes when_____

Name of hospital:_____

Were X-rays taken:_____

Treatment given:_____

_____

Admitted:_____How long:_____

Did you see any other doctors: Yes____ No____

Name, Specialty, Treatment, Dates, Results:_____

_____

_____

_____

Since the injury are the symptoms: Same____ Worse____ Improving____

Circle all symptoms **immediately** after crash: Headache Dizziness Nausea Confusion

Neck Pain Back Pain Paresthesia *if yes where*_____ Pain *where?*_____

What discomfort did you have the **first evening**:_____

_____

Were you able to sleep that night: Yes____ No____

What discomfort did you have the **next day**:_____

_____

Did your injury cause you to miss time from work: Yes____ No____

If so what were the dates of time missed_____

Did you ever have these or similar symptoms before: Yes____ No____

Signature_____ Date_____