ACCIDENT REPORT FORM

NAME_____ **AGE**_____ **DATE OF BIRTH**_____

DATE OF ACCIDENT/INJURY_____ **TIME**_____ **LOCATION**_____

Please describe how accident/injury happened:_____

Please describe in detail your present symptoms:_____

Please describe symptoms immediately following accident/injury:_____

EMPLOYMENT	**Yes**	**No**	**Describe (if any)**
Have you lost any days of work? Please list dates.	☐	☐	
Date of return to work fully.	☐	☐	
Prior to the accident were you able to work on an equal basis with others your age?	☐	☐	
Are any of your activities restricted?	☐	☐	
AUTO ACCIDENT ONLY			
Were you aware of the oncoming accident?	☐	☐	
Were you wearing a seatbelt? Type?	☐	☐	
Were weather conditions a factor? Please describe.	☐	☐	
Were you moving at the time of the accident? Speed?	☐	☐	
If stopped, was your foot on the brake?	☐	☐	
Was the other vehicle moving at the time of the accident?Speed	☐	☐	
Were traffic citations issued? To whom?	☐	☐	
Were you knocked unconscious? If so, how long?	☐	☐	
Were you hospitalized? How did you get there?	☐	☐	
Was your torso or head turned at the time of impact? How?	☐	☐	
Did you have symptoms prior to the accident?	☐	☐	
Where were you seated in the vehicle?	☐	☐	
What is the cost damage to the vehicle you were in?	☐	☐	
Where was the vehicle struck?	☐	☐	
Please list the year, make & model of the care you were in.	☐	☐	
Please list any previous auto accidents.	☐	☐	
How far was the top of headrest from the top of your head?	☐	☐	
Please list the year, make & model of the other vehicle.	☐	☐	

Please check which car parts broke: ☐Rt-Lt side windows ☐Windshield ☐Steering wheel ☐Front/back seat
On what part of the car did the following body parts hit: Head:_____ Chest:_____
Lt/Rt shoulder:_____ Lt-Rt arm:_____ Lt-Rt hip:_____
Lt-Rt leg:_____ Lt-Rt knee:_____ Other:_____

For proper handling of your claim please fully complete.

Check symptoms you have noticed since Accident:

☐ Headache	☐ Constipation	☐ Fainting	☐ Chest Pain
☐ Neck Pain	☐ Diarrhea	☐ Loss of Balance	☐ Depression
☐ Neck Stiffness	☐ Dizziness	☐ Loss of Taste	☐ Loss of Strength
☐ Sleeplessness	☐ Nausea	☐ Loss of Smell	☐ Ringing in Ears
☐ Mid Back Pain	☐ Head Feels Heavy	☐ Cold Hands	☐ Light Sensitivity
☐ Low Back Pain	☐ Numbness in Legs	☐ Cold Feet	☐ Clumsiness
☐ Arm Pain	☐ Numbness in Arms	☐ Loss of Memory	☐ Face Flushed
☐ Leg pain	☐ Numbness in Toes	☐ Disorientation	☐ Cold Sweats
☐ Nervousness	☐ Numbness in Fingers	☐ Unclear Thinking	☐ Upset Stomach
☐ Tense Muscles	☐ Difficulty Breathing	☐ Visual Disturbances	☐ Fever
☐ Irritability	☐ Fatigue	☐ Difficulty Swallowing	☐ _____

Your Auto Insurance:
Company Name:_____
Address:_____
City, State, Zip:_____
Company Phone Number:_____
Policy Number:_____
Claim No. (if known):_____

Driver's Auto Insurance (if different):
Company Name:_____
Address:_____
City, State, Zip:_____
Company Phone Number:_____
Policy Number:_____
Claim No. (if known):_____

Your Health Insurance:
Company Name:_____
Address:_____
City, State, Zip:_____
Company Phone Number:_____
Policy Number:_____

Other Parties Auto Insurance:
Company Name:_____
Address:_____
City, State, Zip:_____
Company Phone Number:_____
Policy Number:_____
Claim No. (if known):_____

Your Attorney (If Any):
Name:_____
Address:_____
City, State, Zip:_____
Phone Number:_____

Doctors or Hospitals Consulted:
Name:_____
Address:_____
City, State, Zip:_____
Dates of Treatment:_____

Signature:_____ **Date:**_____