

### Motor Vehicle Accident History Form

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Your auto insurance company \_\_\_\_\_ Policy No. \_\_\_\_\_ Claim No. \_\_\_\_\_

Claim Representative Name: \_\_\_\_\_ Representative phone number: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Hour: \_\_\_\_\_ a.m./p.m. Location of accident (city): \_\_\_\_\_

Type of vehicles involved in accident (ie: car, truck, suv, etc.) \_\_\_\_\_

Did the police come to the accident scene? Yes No

Was a citation issued? Yes No. For what reason? \_\_\_\_\_

Did the crash occur while on the job? Yes No

Please describe to the best of your ability what happened during this accident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**BEFORE & DURING THE IMPACT**

Were you the: Driver Front Passenger Rear Passenger

Were you wearing a seatbelt? Yes No. Did it hold during the impact? Yes No

Did the airbag inflate? Yes No

Did your seat have a headrest? Yes No

The top of the headrest was: Below Even with Above the top of my head

Were brakes applied? Yes No

If moving, estimated speed of your car was: \_\_\_\_\_ MPH. The other vehicle(s) \_\_\_\_\_ MPH

Road conditions at the time of the accident were: Wet Dry Icy Loose Gravel Other \_\_\_\_\_

Visibility at the time of accident: Clear Cloudy Foggy Other: \_\_\_\_\_

Were there any obstructions involved (example: blind corner, parked vehicle, etc)? \_\_\_\_\_

At impact were you: Surprised Braced for it

**CONCERNING YOU**

After impact did you feel: OK Confused In Pain Emotional Nauseated Had a headache

Did you have time to brace yourself? \_\_\_\_\_

How were you sitting before impact (turned to the right / left / straight ahead, etc)? \_\_\_\_\_

What position were you in following the impact? \_\_\_\_\_

Did you try to grab or restrain anyone? Yes No

Did you lose consciousness (blackout) upon impact? Yes No. If Yes, how long? \_\_\_\_\_

Did you see stars, bright white lights, or did you feel a blinding or explosive sensation in your head? Yes No

What bleeding cuts did you receive during the accident? \_\_\_\_\_

Were you thrown about inside the vehicle? Yes No. On what part of the vehicle did the following body parts hit?:

Head: \_\_\_\_\_ Chest/Back: \_\_\_\_\_

Right/Left Shoulder: \_\_\_\_\_ Right/Left Knee: \_\_\_\_\_

Right/Left Hip: \_\_\_\_\_ Right/Left ankle, foot: \_\_\_\_\_

Right/Left arm, elbow, wrist, hand: \_\_\_\_\_ Other: \_\_\_\_\_

Did any object in the car hit you? Yes No \_\_\_\_\_

Were you taken to the hospital? Yes No. By ambulance? Yes No. Hospital Name \_\_\_\_\_

Were X-rays MRI CT Scan etc, Lab work performed?

Were you given any special instructions and/or medications? \_\_\_\_\_

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**CONCERNING YOUR VEHICLE**

Was the impact from: Front Rear Left Right

Make, year & Model of vehicle you were in: \_\_\_\_\_

Did your car strike the other(s) did the other car strike yours? \_\_\_\_\_

Compared to your car, was the other vehicle: Bigger Smaller The same size

Was the road surface: Dry Wet Icy loose gravel pavement Dirt Mud

The collision moved your vehicle: a little more than a little a lot

Your vehicle was: Stopped Slowing Accelerating

What part of your car was damaged: Front Driver's side Passenger's side Rear

**CONCERNING PREVIOUS ACCIDENTS**

How many prior accidents involving cars have you had: \_\_\_\_\_

How many accidents *not* involving cars? \_\_\_\_\_

Did you get hurt in those? Yes No

Are all your symptoms today due to this accident? Yes No. Explain: \_\_\_\_\_

\_\_\_\_\_