

# MOTOR VEHICLE COLLISION HISTORY

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Agent: \_\_\_\_\_

(Circle all that apply)

Have you retained an attorney? **No** **Yes** Name and Address of Attorney: \_\_\_\_\_

## General Symptoms:

Did you hit part of your body during the collision, for example: head on dash, chest on steering wheel? **No** **Yes**

If yes, which part and how? \_\_\_\_\_

Did you seek medical care after the collision? **No** **Yes** \_\_\_\_\_

Were you hospitalized? **No** **Yes** If yes, where and for how long? \_\_\_\_\_

## Collision History:

Date of Collision: \_\_\_\_\_ Time of Collision: \_\_\_\_\_ A.M. P.M.

Number of Vehicles Involved: \_\_\_\_\_

What type of vehicle were you in? Make: \_\_\_\_\_ Year: \_\_\_\_\_

Were you driving? **No** **Yes** Was it your car? **No** **Yes** If not, whose? \_\_\_\_\_

Passenger? **Front** **Back** **Right Side** **Left Side** Other: \_\_\_\_\_

Were you aware of impending impact? **No** **Yes** Did you brace for impact? **No** **Yes**

Describe your posture in vehicle upon impact? Rotated? Reclined? Looking in rearview mirror? \_\_\_\_\_

State how the Accident happened in your own words: \_\_\_\_\_

Other people in car? **No** **Yes** Names and Addresses: \_\_\_\_\_

Were they injured? **No** **Yes** If yes, please explain: \_\_\_\_\_

Seat belts on? **No** **Yes** Shoulder harness on? **No** **Yes** Position of headrest \_\_\_\_\_

Name: \_\_\_\_\_

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Was it? **Daylight** **Night** **Dark** **Dawn** What were the weather conditions? \_\_\_\_\_

How long had you been in the car? \_\_\_\_\_ What were you doing prior to the collision? \_\_\_\_\_

What were the traffic conditions? \_\_\_\_\_ What was the posted speed limit? \_\_\_\_\_ mph

How fast were you going? \_\_\_\_\_ Type of road: **2 Lane** **4 Lane** **Gravel** **Tar**

Did it happen at a/an: **Stop Sign** **Traffic Light** **Intersection** **Highway**

Was your car hit? **Front** **Back** **Left Side** **Right Side**

What damage was done to your car?

Inside: \_\_\_\_\_

Outside: \_\_\_\_\_

Other: \_\_\_\_\_

If you struck another car, did you strike it: **Front** **Back** **Side**

What was the damage to the other car? Do you have pictures of the involved automobile? **No** **Yes**

Inside: \_\_\_\_\_

Outside: \_\_\_\_\_

In what condition was the vehicle prior to the collision? \_\_\_\_\_

What type of vehicle was involved in the collision?

**Car** **Truck** **Motorcycle** **SUV** **Other:** \_\_\_\_\_ **Size and Type:** \_\_\_\_\_

Was accident report made? **No** **Yes** Police of: **City:** \_\_\_\_\_ **County:** \_\_\_\_\_ **State:** \_\_\_\_\_

Who was ticketed? \_\_\_\_\_ For what? \_\_\_\_\_

Did your vehicle strike anything after the initial impact? **No** **Yes** If yes: **Another Car** **Sign** **Tree**

**Other:** \_\_\_\_\_ **Size and Type:** \_\_\_\_\_

Were you completely conscious after the impact? **No** **Yes** Do you remember the impact? **No** **Yes**

Did your vehicle go off the road? **No** **Yes**

State any strange events that happened during or immediately after the collision:

\_\_\_\_\_

Have you had any time loss from work? **No** **Yes** If yes, from \_\_\_\_\_ to \_\_\_\_\_

Have you ever had to have any outside help? **No** **Yes** What type? \_\_\_\_\_

***The above information is accurate and has been completed to the best of my knowledge:***

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_