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 _____

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Name: _____

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: _____

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