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CAR ACCIDENT INFORMATION

Date of Accident _____ Time of Accident _____ ☐am ☐pm

Please describe the accident in your own words: _____

Were you the: ☐Driver ☐Front Passenger ☐Rear Passenger ☐Pedestrian (not in car)

How many people were in the car? _____

Street Name _____
City/State _____

Make and model of the car you were in:

_____

Were you wearing seatbelt?
☐Full lap and shoulder ☐Lap only
☐Shoulder only ☐No seatbelt

What position were your vehicle headrest in?
☐Lowest position ☐Middle position
☐Highest position ☐No headrest

Was vehicle equipped with airbags? ☐Yes ☐No
If yes, did it inflate properly? ☐Yes ☐No

What was your vehicle doing just prior to accident?
☐Going Straight ☐Slowing down to a stop
☐At a complete stop ☐Increasing speed
☐Merging into traffic ☐Changing lanes
Speed traveling? _____ mph

Who hit who?
☐You were struck by another car
☐You struck another car
☐You struck a stationary object

What was your vehicles point of impact?
☐Front ☐Rear ☐Right side ☐Left side
☐Right front ☐Left front ☐Right rear ☐Left rear

Make and model of the other car:

_____

What was the other vehicle doing just prior to accident?
☐Going Straight ☐Slowing down to a stop
☐At a complete stop ☐Increasing speed
☐Merging into traffic ☐Changing lanes
Speed traveling? _____ mph

What was the other vehicles point of impact?
☐Front ☐Rear ☐Right side ☐Left side
☐Right front ☐Left front ☐Right rear ☐Left rear

Were you prepared for the impact?
☐Came as complete surprise
☐Aware but not braced for collision
☐Aware and braced for collision

Position of your head and neck prior to the impact:
☐Straight forward ☐Tilted forward
☐Rotated to the left ☐Rotated to the right
☐Turned around ☐Toward rear view mirror

That happened to your body at the moment of impact?
☐Tensed for impact ☐Whipped forward/backward
☐Body torqued and twisted ☐Body thrown over seat
☐Body thrown from vehicle ☐Body pinned in vehicle
☐Body thrown from side to side ☐Cut and bruised

Did any part of your body hit anything in the vehicle?
☐Yes ☐No If yes, explain _____

_____

What was your mental/emotional state immediately following the accident?
☐Unconscious ☐Shaken up
☐Disoriented ☐Shaken up & Disoriented

Did you receive medical attention at the scene of the accident? ☐Yes ☐No

Did you go to the hospital? ☐Yes ☐No

When did you go? ☐Immediately after accident
☐Next day ☐2 days or more after accident

Name of hospital and treatment received _____

_____

_____

_____

_____

Did the police come to the accident site? ☐Yes ☐No

Was a police report filed? ☐Yes ☐No

Was a traffic violation issued? ☐Yes ☐No
If yes, to whom? _____

How much does it cost to fix the car? $_____

What is damage of your car? _____

_____

_____

_____

Damage of the other car? _____

_____

_____

_____