Auto Accident Injury Information

Name:_____ **Today's Date:_____**

Date of Accident:___/___/_____
Name of Attorney (If Represented):_____

Please describe how the accident occurred (give details):
_____
_____
_____
_____

What was your position in the vehicle?

( ) The driver **( )** The rear passenger **( )** The front passenger **( )** A pedestrian **( )** Other: _____

What type of vehicle were you driving?

( ) Compact car **( )** Full size car **( )** Full size truck **( )** Full size van **( )** Mid size car **( )** Compact truck **( )** Mini van **( )** Compact ( ) sport utility vehicle **( )** Full size sport utility vehicle **( )** Motorhome **( )** Motorcycle **( )** Bicycle **( )** Other: _____

What speed were you traveling at the time of the accident?

( ) Stopped at a stop light **( )** At a complete stop **( )** Slowing down at an intersection **( )** Moving slowly **( )** Traveling at approximately ___ mph
( ) Merging into traffic **( )** Traveling faster than 65 mph **( )** Other: _____

Who hit whom?

( ) Was struck by another vehicle **( )** Struck a stationary object **( )** Struck another vehicle **( )** Other: _____

What was your vehicle's point of impact?

( ) On the front **( )** On the left front **( )** On the rear **( )** On the left rear **( )** On the right front **( )** On the middle front **( )** On the right rear **( )** On the middle rear
( ) On the right side **( )** On the rear right side **( )** On the left side **( )** On the front right side **( )** On the middle right side **( )** On the front left side
( ) On the rear left side **( )** On the middle left side **( )** Other: _____

What speed was the other vehicle traveling?

( ) Stopped at a stop light **( )** At a complete stop **( )** Slowing down for an intersection **( )** Moving slowly **( )** Merging into traffic **( )** Traveling faster than 65 mph
( ) Traveling at approximately ___ mph **( )** Other: _____

What was the other vehicle's point of impact?

( ) On the front **( )** On the left front **( )** On the rear **( )** On the right front **( )** On the middle front **( )** On the right rear **( )** On the left rear **( )** On the right side **( )** On the rear right side **( )** On the middle rear **( )** On the front right side **( )** On the middle right side **( )** On the left side **( )** On the rear left side
( ) On the front left side **( )** On the middle left side **( )** Other: _____

Were you wearing seat restraints?

( ) Was wearing a full lap and shoulder restraint **( )** Was wearing a shoulder restraint **( )** Was wearing a lap restraint **( )** Was not wearing any seat restraints
( ) Other: _____

What position were your vehicle head rests in?

( ) Did have a head rest which was adjusted in the lowest position **( )** Did have a head rest which was adjusted in the middle position
( ) Did have a head rest which was adjusted in the highest position **( )** Was not equipped with a head rest
( ) Other: _____

Did your air bag deploy?

( ) Air bags were deployed **( )** Air bags were not deployed **( )** Other:_____

Were you prepared for the impact?

( ) Was completely surprised by the accident **( )** Saw the collision coming and braced appropriately **( )** Saw the collision coming
( ) Other: _____

What position was your body in just prior to impact?

( ) A straight position **( )** A position rotated to the left **( )** A tilted forward position **( )** A position rotated to the right **( )** A position that cannot be remembered
( ) Other: _____

What happened to your body the moment of impact?

( ) Body was tensed for impact **( )** Body violently torqued and twisted **( )** Body whipped violently forward and backward **( )** Body was thrown over the seat
( ) Body was thrown from the vehicle **( )** Body was thrown violently from side to side **( )** Body was pinned in the vehicle **( )** Body was badly cut and bruised
( ) Other: _____

What was your mental/emotional state immediately following the accident?

( ) Was not rendered unconscious by the impact of the accident **( )** Was rendered unconscious by the impact of the accident
( ) Was not rendered unconscious but was shaken and disoriented **( )** Was not rendered unconscious but was shaken up
( ) Was not rendered unconscious but was disoriented **( )** Other: _____

Did you receive medical attention at the scene of the accident?

( ) Did receive medical attention **( )** Did not receive medical attention **( )** Other: _____

Where did you go immediately following the accident?

( ) Was taken to the hospital by ambulance **( )** Was driven to hospital **( )** Was taken to a personal physician **( )** Was taken home **( )** Was taken to this office
( ) Resumed activities **( )** Other: _____
If Hospitalized, how long? _____
Hospital Name:_____

Did your symptoms develop?

( ) Immediately ( ) Hours later ( ) The next day ( ) Over the first few days ( ) During the first week ( ) Over the next few weeks

If you were treated by another doctor or therapist, answer the following questions:

Name of doctor or facility:_____
Date of Exam:___/___/_____
Treatment received: ( ) X-rays ( ) CT Scan ( ) MRI What body part(s)?_____
Was Medication prescribed? ( )YES ( )NO
Date of last appointment: ___/___/_____

Name of doctor or facility:_____
Date of Exam:___/___/_____
Treatment received: ( ) X-rays ( ) CT Scan ( ) MRI What body part(s)?_____
Was Medication prescribed? ( )YES ( )NO
Date of last appointment: ___/___/_____

List each of your body parts that struck the following vehicle parts during the accident (Answer if applicable)

Dashboard:

_____

Windshield:

_____

Steering Wheel:

_____

Right Door:

_____

Left Door:

_____

Seat Frame:

_____

Unknown Object: _____

_____