NAME______________________________DATE____________________

VEHICLE ACCIDENT INFORMATION:

Date of Accident:	Time of Accident: am ! pm !
Road/Street Name:	
City, State:	Direction You Were Headed:
Nearest Intersection with Road/Street:	
Driving Conditions: Dry ! Wet ! Icy ! Other !	Speed You Were Traveling:
Were you the : Driver ! Front Passenger ! Rear Passenger ! Pedestrian !	How many people were in the accident vehicle:
Make and Model of the Vehicle You Were In:	
Were You Wearing a Seatbelt: ! Yes ! No	If Yes, What Type: ! Shoulder Harness ! Lap Belt
Was Vehicle Equipped with Airbag? ! Yes ! No	If Yes, did it/they inflate properly: ! Yes ! No
Did Your Seat Have a Headrest: ! Yes ! No	If Yes, What was the Position of the Headrest: ! Low ! High ! Mid
Did Any Part of Your Body Strike the Inside of the Vehicle: ! Yes ! No Describe:	
Did Your Car Impact Another Vehicle: ! Yes ! No	Another Structure: ! Yes ! No
Make and Model of Other Vehicle:	Speed of Other Vehicle:
Direction of Other Vehicle:	
Was Impact from: ! Rear ! Front ! Left ! Right ! Other	
At the Time of Impact Were You: Looking Straight Ahead ! Looking to the Left ! Looking to the Right ! Looking Up ! Down !	
Were Both Hands on the Steering Wheel: ! Yes ! No	If Not, Which Hand was on the Wheel:
Was Your Foot on the Brake: ! Yes ! No	
Were You: ! Surprised by the Impact ! Braced for the Impact	
Did the Police Come to the Accident Site: ! Yes ! No	Was a Report Filed: ! Yes ! No
Were there any Witnesses: ! Yes ! No	Was a Traffic Violation Issued: ! Yes ! No To Whom:
Describe the Accident in Your Own Words:	
Were you Unconscious after the Accident: ! Yes ! No	
Did You go to the Hospital: ! Yes ! No By Ambulance: ! Yes ! No	Next Day: ! Yes ! No Other:
Name of Hospital:	Name of Doctor:
Diagnosis:	
Treatment Received:	
X-Rays Taken:	
Have you been able to work since the accident: ! Yes ! No	If not, how many days have you missed: