Name_____ Date_____

Date of accident_____

What time did the accident occur? _____

How many vehicles were involved in the accident? _____

What was the estimated damage to the vehicle you were in? _____

What state and city did the accident occur? _____

What street or intersection did the accident happen? _____

What direction were you traveling in? _____

What type of impact was the accident? _____

Did your vehicle hit anything after the accident? If yes, please describe

_____

Where were you sitting in the vehicle during the accident? _____

Did you know the accident was coming? _____

What type of vehicle impacted yours? _____

At the time of impact, how fast was your vehicle traveling? _____

At the time of impact, how fast was the other vehicle traveling? _____

During the crash what happened to your vehicle? (Circle all that apply)

-Kept going straight -spun around -kept going straight hitting car in front

- Hit by another vehicle -spun around and hit a stationary object -hit a stationary object

Did you lose consciousness during the accident? _____

How was your head positioned during the accident? _____

How was your torso positioned during the accident? _____

Did your head hit anything during the accident? _____

Did your face hit anything during the accident? _____

Did your shoulders hit anything during the accident? _____

Did your neck hit anything during the accident? _____

Did your chest hit anything during the accident? _____

Did your hips hit anything during the accident? _____

Did your knees hit anything during the accident? _____

Did your feet hit anything during the accident? _____

What kind of headrest was in your vehicle?

- Moveable fixed headrest - non-movable headrest - no headrest

Where was the headrest positioned on your head? _____

Did you have your seat belt on during the accident? Yes No

What was the damage to the vehicle (circle all that apply)

-Windshield -steering wheel -dashboard -seat frame -side window -rear window

-Rear bumper front bumper -trunk -front left door -front right door

-Back left door -mirror -knee bolster -back right door -Totaled

Choose the items that dented inward -floorboards -side door -dashboard

Choose the doors that would not open as a result of the accident

-Front right -front left -back right -back left

Did you go to the hospital? _____

*How did you get there? _____

*What was the name of the hospital? _____

*Were you hospitalized overnight? _____

*Circle what your were prescribed -pain medication -muscle relaxer - neck brace

*Did you receive any stitches? _____

*Were x-rays taken? If yes what areas? _____

CLAIM INFORMATION:

Auto Insurance Carrier _____

Adjuster Name _____

Adjuster phone number _____

Auto Claim number _____