Vehicle Accident Report

Name: ____

Date of Accident: _______/________/________ Time of Accident: ______ : _______ (AM / PM)

Question	Answer
Were you?	A) Driver B) Passenger (front) (rear) (right – left) C) Pedestrian
Were you wearing Seat Belt?	YES ____ NO _____
Type of Vehicle:	A) Auto B) Truck (compact) C) Van (mini) D) Motorcycle E) Motor home F) Bicycle G) SUV (compact/full-size)
How Accident occurred:	A) Struck by another vehicle B) Struck another vehicle C) Struck a stationary object D) Other:
Where was your vehicle hit?	A) Front B) Rear C) Rt. Side D) Lft. Side E) Rt. Front F) Lft. Front G) Rt. Rear H) Lft. Rear.
Where was other vehicle hit?	A) Front B) Rear C) Rt. Side D) Lft. Side E) Rt. Front F) Lft. Front G) Rt. Rear H) Lft. Rear.
Your approximate speed	__________ MPH
Other vehicle approx. speed	__________ MPH
What occurred at the moment of impact? (Circle as many as apply) (prepared/unprepared)	A) Tense Body for impact B) Neck whipped forward and back C) Spine torqued and twisted D) Thrown over seat E) Thrown from vehicle F) Pinned in vehicle G) Thrown from side to side H) Cut and bruised
Did your strike your: (circle as many as apply)	
• Head Against the:	1)Dashboard 2)Windshield 3)Steering wheel 4) Rt. Door 5) Lft. Door 6)Seat frame 7)Unknown object
• Shoulder (Lft/Rt) Against the:	1)Dashboard 2)Windshield 3)Steering wheel 4) Rt. Door 5) Lft. Door 6)Seat frame 7)Unknown object
• Arm (Lft/Rt) Against the:	1)Dashboard 2)Windshield 3)Steering wheel 4) Rt. Door 5) Lft. Door 6)Seat frame 7)Unknown object
• Elbow (Lft/Rt) Against the:	1)Dashboard 2)Windshield 3)Steering wheel 4) Rt. Door 5) Lft. Door 6)Seat frame 7)Unknown object
• Wrist (Lft/Rt) Against the:	1)Dashboard 2)Windshield 3)Steering wheel 4) Rt. Door 5) Lft. Door 6)Seat frame 7)Unknown object
• Hip (Lft/Rt) Against the:	1)Dashboard 2)Windshield 3)Steering wheel 4) Rt. Door 5) Lft. Door 6)Seat frame 7)Unknown object
• Knee (Lft/Rt) Against the:	1)Dashboard 2)Windshield 3)Steering wheel 4) Rt. Door 5) Lft. Door 6)Seat frame 7)Unknown object
• Ankle (Lft/Rt) Against the:	1)Dashboard 2)Windshield 3)Steering wheel 4) Rt. Door 5) Lft. Door 6)Seat frame 7)Unknown object
Where you rendered unconscious?	(Y / N) How long? ________ **Did you receive medical attention at the scene of the accident?** Yes ____ No ______
Where did you go immediately following the accident?	A)Hospital B)Home C)Personal doctor D)To this office E)Resumed activities
Were you: (Circle as many as possible)	Shaken – Disoriented – Scared – Nervous – Nauseous – Dizzy - Vomited Other: ____
Did You have any physical complaints before the accident?	(Y – N) If "YES" describe: ______________________________________ ____
In Your own words, please describe accident:	
Car Damage	MILD – MODERATE – SEVERE – TOTAL
How did you feel immediately after the accident?	

Important: *This form may be used in the determination of insurance benefits and/or litigation for compensation. It is imperative that this form be filled out completely to protect your rights of compensation.*