

NAME \_\_\_\_\_ DATE \_\_\_\_\_

**VEHICLE ACCIDENT INFORMATION:**

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