

MOTOR VEHICLE ACCIDENT INJURY REPORT

Name: _____ Today's Date: _____

Date of Accident: ____/____/____

Describe how the accident happened in your own words:

Was the accident reported to Police Department _____ Yes _____ No Number of people in your car _____

Were traffic citations issued to? You _____ Driver of your car _____ Driver of other car _____ None _____

Do you have a copy of the police report? _____ Yes _____ No If so, please provide a copy to the front desk.

What kind of vehicle were you in? _____ Truck _____ Car _____ Motorcycle _____ Other: _____

Make: _____ Model _____ Unknown: _____

You were a _____ Driver _____ Passenger _____ Pedestrian

If a passenger, were you sitting in _____ Front _____ Right Rear _____ Left Rear

Do you remember the position of your body at the time of impact?

_____ looking left _____ looking right _____ looking forward _____ looking over shoulder _____ looking down

Position of your cervical restraint (head rest) : _____ raised or _____ lowered position

Did other vehicles collide with your vehicle? Yes _____ No _____ If yes, please circle all that apply to how the other vehicle struck your vehicle:

Head-on Left Side Impact Right Side Impact Rear-ended

Did your vehicle collide with other vehicles? Yes _____ No _____ If yes, please circle all that apply to how your vehicle struck the other vehicle:

Head-on Left Side Impact Right Side Impact Rear-ended

Estimated speed of your vehicle at impact? _____ MPH Estimated speed of other vehicle at impact? _____ MPH

What kind of vehicle hit yours? _____ Truck _____ Car _____ Motorcycle _____ Other: _____

Make: _____ Model _____ Unknown: _____

Were your brakes applied at the time of impact? _____

Did your car move any distance after impact? _____ If yes, how far? _____

Any damage to your vehicle? _____ Other vehicle? _____

Were you wearing a seat belt? ____ Yes ____ No

Did you strike anything in the vehicle at the time of impact? ____ Yes ____ No

If yes, specify: ___steering wheel ___dashboard ___windshield ___side door ___arm rests ___side window

Please state part of body: ___chest ___chin ___knee ___shoulder ___hand ___head ___other: _____

Do you have any visible bruises, cuts, or scrapes? _____

Was your car driveable after the accident? ____ Yes ____ No

Did ambulance personnel treat you at the scene? ____ Yes ____ No

Did an ambulance transport you to the hospital? ____ Yes ____ No

Did you go to the hospital? ____ Yes ____ No If so, where and when: _____

Were x-rays taken? ____ Yes ____ No If so, of what? _____

Any other diagnostic tests performed, such as MRI or CT scan? ____ Yes ____ No

Were you admitted to the hospital? ____ Yes ____ No Were you treated and released? ____ Yes ____ No

Were you provided medication? ____ Yes ____ No

If so, what kind of medication? _____

Name of family physician: _____

Have you seen your family physician? ____ Yes ____ No ____ I do not have a family physician.

Please list all of your current complaints of pain that you relate to the motor vehicle accident:

Do you have insurance on your motor vehicle? ____ Yes ____ No
If so, please provide a copy of your insurance card to the front desk.

Do you have health insurance? ____ Yes ____ No
If so, please provide a copy of your insurance card to the front desk.

Vehicle you were in:

Have you contacted your insurance Company? _____

Driver _____

Insured _____

Address _____

Phone _____

Auto Insurance Co _____

Ins. Co Address _____

Adjuster _____

Phone # _____

Policy # _____

Claim # _____

Your Insurance Agent's Name/phone #: _____

Other vehicle's information:

Has a representative of the other person's insurance company contacted you? ____ Yes ____ No

Date Contacted _____ By: _____ Insurance Company _____

Driver _____

Insured Person _____

Address _____

Phone _____

Auto Insurance Co _____

Ins. Co Address _____

Adjuster _____

Phone # _____

Policy # _____

Claim # _____

Have you retained an attorney? _____ yes _____ no

Name of Attorney: _____

Attorney Phone Number: _____

Any other necessary information:
