

AUTO ACCIDENT REPORT

Your Name: _____ Accident Date: _____

Today's Date: _____ Accident Location: _____

Year, Make, Model _____

Road Conditions? Wet Icy Other Other Vehicles Involved? _____

Did police come to the scene? Yes No Is there a report? Yes No

Impact locations on Car(s)? _____

Was your car: Accelerating Decelerating Even Speed Stopped

Was your foot on the brake? Yes No Was your chest/body facing forward? Yes No

Was your head facing? Forward Looking right Looking Left Looking Back

Did you go to the hospital? Yes No

If yes, how did you get to the hospital? _____

How long did you stay? _____

What bleeding cuts did you sustain? _____

What bruises did you sustain? _____

Did you lose consciousness as a result of the accident? Yes No For how long? _____

Did you become: (Please circle) Initially Confused Disoriented Light Headed

Dizzy Nauseated Blurred Vision Ringing/Buzzing in Ears from Accident

Which of these symptoms do you still have? _____

Are you currently suffering from the following? (Please circle)

Restlessness Irritability Sleeplessness Difficulty Concentrating

Difficulty with Memory Forgetfulness Reduced tolerance to Heat

Reduced Tolerance to Alcohol

Was the other car: Accelerating Decelerating Even Speed Stopped

On the backside of this form, please give your description of the events of the accident.