

Auto Accident Information

Date and time of accident: _____

Year and make of your vehicle: _____

Year and make of other vehicle that hit you or you hit: _____

Speed of your vehicle: _____ Speed of other vehicle: _____

Position of your vehicle: stopped at intersection stopped at traffic
 stopped at light making a right turn making a left turn
 parking proceeding along accelerating
 slowing down other _____

Point of impact: rear-end head-on left front right front left rear right rear
Visibility: poor fair good
Condition of road: icy wet sandy dark clean & dry

Amount damage to your vehicle: \$ _____ totaled

Seat belt on? Yes No

What position of your headrest at time of accident: straight left right

Did your body hit the inside of vehicle? No Yes – where? _____

Did you lose consciousness during the injury? No Yes – where? _____

Did the police come? No Yes – Ticket given? Y N Written report? Y N

Ambulance come? No Yes – Did you go to the ER with them?

What was done at the ER? Exam / X-rays / MRI / Other - _____

Did you see any other doctors? No Yes – who? _____

Drawing the accident:

