

# ACCIDENT REPORT FORM

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_ Phone # \_\_\_\_\_

DATE OF ACCIDENT \_\_\_\_\_ TIME \_\_\_\_\_ A.M. / P.M. Were police notified? Yes / No

WERE YOU THE: DRIVER \_\_\_\_\_ PASSENGER \_\_\_\_\_ (front seat, back seat) PEDESTRIAN \_\_\_\_\_ CYCLIST \_\_\_\_\_

WHAT TYPE OF VEHICLE WERE YOU TRAVELING IN? (car, truck, make, & year) \_\_\_\_\_

WHAT TYPE OF VEHICLE HIT YOU OR DID YOU HIT \_\_\_\_\_ ROAD CONDITIONS \_\_\_\_\_

HOW MUCH DAMAGE WAS DONE TO YOUR VEHICLE \_\_\_\_\_

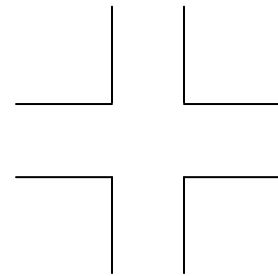
PLEASE EXPLAIN IN DETAIL THE PLACE OF THE ACCIDENT & HOW IT HAPPENED \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



WERE YOU STRUCK FROM: BEHIND \_\_\_ THE FRONT \_\_\_ LEFT SIDE \_\_\_ RIGHT SIDE \_\_\_ Sketch the Accident

WHAT SPEED WERE YOU GOING WHEN HIT \_\_\_\_\_ STOPPED OR PARKED \_\_\_\_\_

WHAT APPROXIMATE SPEED WAS THE CAR GOING THAT HIT YOU \_\_\_\_\_

AFTER YOU WERE HIT DID YOU STRIKE ANOTHER CAR OR ANYTHING ELSE \_\_\_\_\_

WERE YOU AWARE OF THE ONCOMING ACCIDENT \_\_\_\_\_ WERE SEATBELTS IN USE \_\_\_\_\_ SHOULDER STRAPS \_\_\_\_\_

LAP RESTRAINTS \_\_\_\_\_ MOTORCYCLE HELMET \_\_\_\_\_ DOES YOUR SEAT HAVE A HIGH-BACK OR HEADREST \_\_\_\_\_

AT THE TIME OF THE ACCIDENT WERE YOU FACING OR LOOKING: IN MIRROR \_\_\_ STRAIGHT AHEAD \_\_\_ OR WERE YOU:

TURNED TO THE LEFT \_\_\_ TURNED TO RIGHT \_\_\_ TOSSED OR THROWN ABOUT \_\_\_\_\_

DID YOUR BODY STRIKE ANY PARTICULAR OBJECT \_\_\_\_\_

WERE YOU ABLE TO GET OUT AND WALK \_\_\_\_\_ WERE YOU CONSCIOUS AT ALL TIMES \_\_\_\_\_

COULD YOU MOVE ALL PARTS OF YOUR BODY \_\_\_\_\_ WAS AN AMBULANCE CALLED \_\_\_\_\_

DID YOU GO TO A HOSPITAL \_\_\_\_\_ WHICH ONE \_\_\_\_\_ HOW LONG WERE YOU THERE \_\_\_\_\_

WHAT WAS DONE AT THE HOSPITAL: X-RAYS \_\_\_ EXAMINATION \_\_\_ MEDICATION \_\_\_ WHAT KIND & WHAT FOR \_\_\_\_\_

\_\_\_\_\_ WHAT WERE YOU TOLD WAS WRONG WITH YOU (DIAGNOSIS) \_\_\_\_\_

\_\_\_\_\_

DID THE ACCIDENT HAPPEN WHILE WORKING ON THE JOB \_\_\_ HAVE YOU SEEN ANY OTHER DOCTORS SINCE THE ACCIDENT

(who, when, how often, diagnosis, treatment provided) \_\_\_\_\_

\_\_\_\_\_

HAVE YOU SEEN A PHYSICAL THERAPIST OR REHAB (who, when, how often, type of treatment) \_\_\_\_\_

\_\_\_\_\_

HAVE YOU HAD ANY X-RAYS OF THE INJURED AREA PRIOR TO OR SINCE THE ACCIDENT \_\_\_\_\_

BEFORE YOU WERE INJURED WERE YOU CAPABLE OF WORKING ON AN EQUAL BASIS WITH OTHERS YOUR OWN AGE \_\_\_\_\_

HAVE YOU HAD ANY PREVIOUS CAR ACCIDENT OR INJURY IN A SIMILAR MANNER \_\_\_\_\_ WHEN \_\_\_\_\_

HAVE YOU MISSED WORK \_\_\_\_\_ FROM \_\_\_\_\_ TO \_\_\_\_\_

CONTINUE ON BACK →

**CIRCLE SYMPTOMS YOU HAVE NOTICED SINCE YOUR ACCIDENT**

**HEAD INJURIES**

HEADACHES  
LOSS OF MEMORY  
LIGHT-HEADEDNESS  
TENSION  
FAINTING  
EYE COMPLAINTS  
BLURRED VISION  
LOSS OF BALANCE  
DIZZINESS  
LOSS OF HEARING  
LOSS OF SMELL  
LOSS OF TASTE  
PAIN IN THE EARS  
EAR NOISES  
LIGHTS BOTHER EYES  
FACE FLUSHED  
FACIAL MUSCLE DISTURBANCES  
NASAL DISTURBANCES  
JAW PAIN  
HEAVINESS OF HEAD  
NAUSEA

**NECK INJURIES**

NECK PAIN  
STIFFNESS OF NECK  
SORENESS OF NECK  
DIFFICULT NECK MOVEMENT  
MUSCLE SPASM IN NECK  
GRINDING SOUND IN NECK  
DIFFICULTY SWALLOWING

**SHOULDER, ARM & CHEST INJURIES**

SHOULDER JOINT PAIN  
PAIN BETWEEN SHOULDERS  
CAN NOT RAISE ARM OR HAND  
MUSCLE SPASM IN SHOULDERS  
COLD HANDS  
ELBOW, FINGER, OR WRIST PAIN  
SHORTNESS OF BREATH  
RIB PAIN  
CHEST PAIN  
TROUBLE BREATHING  
NUMBNESS, PAIN, OR TINGLING IN  
ARMS, HANDS, OR FINGERS

**LOWER BACK AND LEG INJURIES**

PAINFUL TAILBONE  
LOW BACK PAIN  
DIFFICULTY STANDING ERECT  
BACK AGGRAVATED BY WORKING,  
LIFTING, STOOPING, SITTING,  
BENDING, COUGHING, OR LYING  
NUMBNESS, PAIN, OR TINGLING IN  
EITHER LEG  
MUSCLE SPASM IN LEG  
PAIN IN BUTTOCKS, KNEES, CALF,  
ANKLE, FOOT, OR TOES  
COLD FEET  
SWOLLEN ANKLES  
PAIN IN HIP  
DIFFICULTY WALKING  
FREQUENT OR DIFFICULT URINATION

**GENERAL SYMPTOMS**

UPSET STOMACH  
COLD SWEATS  
FATIGUE  
FEVER  
ABDOMINAL DISCOMFORT  
GAS  
CONSTIPATION  
DIARRHEA  
ANXIETY  
IRRITABILITY  
DEPRESSION  
MOOD OR BEHAVIOR CHANGES  
INSOMNIA  
LOSS OF WEIGHT  
NERVOUSNESS OR RESTLESSNESS  
LOSS OF APPETITE  
BRUISES  
LACERATIONS  
BROKEN BONES  
INCREASED RESPIRATION  
INABILITY TO CONCENTRATE  
HEART PALPITATION  
RAPID HEART BEAT  
AFRAID OF AUTOMOBILES  
AFRAID OF DRIVING  
TREMORS  
TWITCHES  
LOSS OF NORMAL SEX FUNCTION  
MENTAL DULLNESS  
BLACKOUTS/FAINTING

CURRENT SYMPTOMS, OTHER THAN ABOVE \_\_\_\_\_

WHAT WERE THE IMMEDIATE COMPLAINTS OF INJURIES AFTER THE ACCIDENT (pain, cuts, bruises, etc.) AND WHERE \_\_\_\_\_

\_\_\_\_\_

WHAT ADDITIONAL COMPLAINTS HAVE DEVELOPED SINCE THE ACCIDENT \_\_\_\_\_

\_\_\_\_\_

WERE YOU SUFFERING ANY OF THESE SYMPTOMS PRIOR TO THE ACCIDENT \_\_\_\_\_ IF YES, EXPLAIN \_\_\_\_\_

\_\_\_\_\_

SINCE THE INJURY, HAVE YOUR SYMPTOMS: IMPROVED \_\_\_\_\_ WORSENERD \_\_\_\_\_ REMAINED THE SAME \_\_\_\_\_

**DRIVER OF OTHER VEHICLE (IF ANY)**

NAME \_\_\_\_\_ INSURANCE COMPANY \_\_\_\_\_ POLICY NO. \_\_\_\_\_

DRIVER OF VEHICLE IN WHICH YOU WERE INJURED (IF APPLICABLE)

NAME \_\_\_\_\_ INSURANCE COMPANY \_\_\_\_\_ POLICY NO. \_\_\_\_\_

NAME OF YOUR INSURANCE ADJUSTER \_\_\_\_\_ PHONE # \_\_\_\_\_

HAVE YOU RETAINED AN ATTORNEY FOR THE INJURY YES \_\_\_\_\_ No \_\_\_\_\_ WHAT IS HIS NAME, ADDRESS & PHONE # \_\_\_\_\_

\_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_