VEHICLE ACCIDENT REPORT

Name_____

1. Date of Accident _____/_____/_____ 2. Time of Accident_____

3. Were you: A) Driver B) passenger (front) C) Passenger (back) D) Pedestrian

4. Were you wearing a seatbelt? (Y/N)

5. Type of vehicle: A) Auto B) Truck C) Van D) Motorcycle E) Motorhome F) bicycle

6. How accident occurred: A) Struck by another vehicle B) struck another vehicle
C) Struck a stationary object D) Other _____

7. Where was the vehicle hit? A) Front B) Rear C) Rt. side D) Lf. side E) Rt. front F) Lf. front
G) Rt. rear H) Lf. rear

8. Where was the other vehicle hit? A) Front B) Rear C) Rt. side D) Lf. side E) Rt. front F) Lf. front
G) Rt. rear H) Lf. rear

9. Your approximate speed _____mph 10. Other vehicle approximate speed _____mph

11. What occurred at the moment of impact? (Circle as many as apply)
A) Tensed body for impact B) Neck whipped forward & back C) Spine torqued & twisted
D) Thrown over seat E) Thrown from vehicle F) Pinned in vehicle G) Thrown from side to side
H) Cut and bruised

12. Did you strike your : (Circle as many as apply)
A) HEAD Against the: 1) Dashboard 2) Windshield 3) Steering wheel 4) Rt. door 5) Lf. door
6) Seat Frame 7) Unknown
B) SHOULDER Against the: 1) Dashboard 2) Windshield 3) Steering wheel 4) Rt. door
5) Lf. door 6) Seat Frame 7) Unknown
C) ARM Against the: 1) Dashboard 2) Windshield 3) Steering wheel 4) Rt. door 5) Lf. door
6) Seat Frame 7) Unknown
D) ELBOW Against the: 1) Dashboard 2) Windshield 3) Steering wheel 4) Rt. door 5) Lf. door
6) Seat Frame 7) Unknown
E) WRIST Against the: 1) Dashboard 2) Windshield 3) Steering wheel 4) Rt. door 5) Lf. door
6) Seat Frame 7) Unknown
F) HIP Against the: 1) Dashboard 2) Windshield 3) Steering wheel 4) Rt. door 5) Lf. door
6) Seat Frame 7) Unknown
G) KNEE Against the: 1) Dashboard 2) Windshield 3) Steering wheel 4) Rt. door 5) Lf. door
6) Seat Frame 7) Unknown
H) ANKLE Against the: 1) Dashboard 2) Windshield 3) Steering wheel 4) Rt. door 5) Lf. door
6) Seat Frame 7) Unknown

13. Were you rendered unconscious? (Y/N)

14. Did you receive medical attention at the scene of the accident? (Y/N)

15. Where did you go immediately following the accident?
A) Hospital B) Home C) Personal doctor D) To this office E) Resume activities

16. Were you: (Circle as many as apply) A) Shaken B) Disoriented

Did you have any physical complaints before the accident? (Y/N) If yes please describe: _____

_____

_____

In your own words please describe the accident: _____

_____

_____

How did you feel immediately after the accident? _____

_____

_____

Important: this form may be used in the determination of insurance benefits and/ or litigation for compensation. It is imperative that this form be filled out completely to protect your rights of compensation.