Name: _____

1. What was the date the accident occurred? _____
2. What time did the accident occur? _____
3. How many vehicles were involved in the accident? _____
4. What was the estimated damage to the vehicle you were in? _____
5. What city & state did the accident occur in? _____
6. What street or intersection were you on when the accident occurred? _____
7. What direction were you traveling in? _____
8. What type of impact was the auto accident? _____
9. Did your vehicle hit anything after the accident? If yes, please describe: _____
10. Where were you sitting in the vehicle during the accident? _____
11. Did you know the accident was going to occur? _____
12. What type of vehicle were you in? _____
13. What type of car impacted yours? _____
14. At the time of impact, how fast was your vehicle moving? _____
15. At the time of impact, how fast was the other vehicle moving? _____

16. During and after the crash, what happened to your vehicle? (circle all that apply)
    - kept going straight
    - spun around
    - kept going straight hitting a car in front
    - spun around & hit a stationary object
    - was hit by another vehicle
    - hit a stationary object

17. Did you lose consciousness during the accident? _____

18. How was your head positioned during the accident? _____

19. How was your torso positioned during the accident? _____

20. How were your hands positioned during the accident? _____

21. Did your head hit anything during the accident? - no - yes, please describe:
    _____

22. Did your face hit anything during the accident? - no - yes, please describe:
    _____

23. Did your shoulders hit anything during the accident? - no - yes, please describe:
    _____

24. Did your neck hit anything during the accident? - no - yes, please describe:
    _____

25. Did your chest hit anything during the accident? - no - yes, please describe:
    _____

26. Did your hips hit anything during the accident? - no - yes, please describe:
    _____

27. Did your knees hit anything during the accident? - no - yes, please describe:
    _____

28. Did your feet hit anything during the accident? - no - yes, please describe:
    _____

29. What kind of headrest was in your vehicle?
    - Movable fixed headrest
    - non-movable fixed headrest
    - no headrest

30. Where was the headrest positioned on your head? _____

31. Did you have your seatbelt on during the accident? – yes - no

32. What was damaged on your vehicle?
    _____
    _____

33. Did you go to the hospital? If not, skip to question 40. _____

34. How did you get to the hospital? _____

35. What was the name of the hospital? _____

36. Were you hospitalized overnight? _____

37. Circle what you were prescribed at the hospital:
    - pain medication - muscle relaxers - neck brace

38. Did you receive any stitches for any cuts at the hospital? _____

39. Were xrays taken at the hospital? If yes, which area was taken?
    _____

40. Insurance company for us to mail claims: _____

41. Claim #: _____

42. Adjustor Name: _____

43. Phone #: _____ extension: _____

44. Medical Limit: $_____