## ACCIDENT REPORT FORM

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGE</th>
<th>DATE OF BIRTH</th>
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<tbody>
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<table>
<thead>
<tr>
<th>DATE OF ACCIDENT/INJURY</th>
<th>TIME</th>
<th>LOCATION</th>
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Please describe how accident/injury happened:

________________________________________________________________________

________________________________________________________________________

Please describe in detail your present symptoms:

________________________________________________________________________

________________________________________________________________________

Please describe symptoms immediately following accident/injury:

________________________________________________________________________

________________________________________________________________________

### EMPLOYMENT

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Describe (if any)</th>
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Have you lost any days of work? Please list dates.

Date of return to work fully.

Prior to the accident were you able to work on an equal basis with others your age?

Are any of your activities restricted?

### AUTO ACCIDENT ONLY

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Describe (if any)</th>
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Were you aware of the oncoming accident?

Were you wearing a seatbelt? Type?

Were weather conditions a factor? Please describe.

Were you moving at the time of the accident? Speed?

If stopped, was your foot on the brake?

Was the other vehicle moving at the time of the accident? Speed?

Were traffic citations issued? To whom?

Were you knocked unconscious? If so, how long?

Were you hospitalized? How did you get there?

Was your torso or head turned at the time of impact? How?

Did you have symptoms prior to the accident?

Where were you seated in the vehicle?

What is the cost damage to the vehicle you were in?

Where was the vehicle struck?

Please list the year, make & model of the care you were in.

Please list any previous auto accidents.

How far was the top of headrest from the top of your head?

Please list the year, make & model of the other vehicle.
Please check which car parts broke: □ Rt-Lt side windows □ Windshield □ Steering wheel □ Front/back seat
On what part of the car did the following body parts hit: Head: _______________ Chest: _______________
Lt/Rt shoulder: _______________ Lt-Rt arm: _______________ Lt-Rt hip: _______________
Lt-Rt leg: _______________ Lt-Rt knee: _______________ Other: _______________

For proper handling of your claim please fully complete.

Check symptoms you have noticed since Accident:

□ Headache □ Constipation □ Fainting □ Chest Pain
□ Neck Pain □ Diarrhea □ Loss of Balance □ Depression
□ Neck Stiffness □ Dizziness □ Loss of Taste □ Loss of Strength
□ Sleeplessness □ Nausea □ Loss of Smell □ Ringing in Ears
□ Mid Back Pain □ Head Feels Heavy □ Cold Hands □ Light Sensitivity
□ Low Back Pain □ Numbness in Legs □ Cold Feet □ Clumsiness
□ Arm Pain □ Numbness in Arms □ Loss of Memory □ Face Flushed
□ Leg pain □ Numbness in Toes □ Disorientation □ Cold Sweats
□ Nervousness □ Numbness in Fingers □ Unclear Thinking □ Upset Stomach
□ Tense Muscles □ Difficulty Breathing □ Visual Disturbances □ Fever
□ Irritability □ Fatigue □ Difficulty Swallowing □ ____________

Your Auto Insurance:  Driver’s Auto Insurance (if different):
Company Name: _____________________________  Company Name: _____________________________
Address: ___________________________________  Address: ___________________________________
City, State, Zip: _____________________________  City, State, Zip: _____________________________
Company Phone Number: _____________________  Company Phone Number: _____________________
Policy Number: ______________________________  Policy Number: ______________________________
Claim No. (if known): __________________________  Claim No. (if known): __________________________

Your Health Insurance:  Other Parties Auto Insurance:
Company Name: _____________________________  Company Name: _____________________________
Address: ___________________________________  Address: ___________________________________
City, State, Zip: _____________________________  City, State, Zip: _____________________________
Company Phone Number: _____________________  Company Phone Number: _____________________
Policy Number: ______________________________  Policy Number: ______________________________
Claim No. (if known): __________________________  Claim No. (if known): __________________________

Your Attorney (If Any):  Doctors or Hospitals Consulted:
Name: ______________________________________  Name: ______________________________________
Address: ____________________________________  Address: ___________________________________
City, State, Zip: ______________________________  City, State, Zip: _____________________________
Phone Number: _______________________________  Dates of Treatment: __________________________
Signature: ___________________________________  Date: _______________________________________