PROLIANCE ORTHOPAEDICS & SPORTS MEDICINE
BELLEVUE • ISSAQUAH

Motor Vehicle Accident Information Sheet

Name: ____ Date: ______________

This form is meant for you to provide us with accurate information about your accident should the insurance company or your attorney request it, or in case of the necessity of legal testimony. It may be referred to in other documents in your medical record in the future. If you have been in multiple accidents in the past the questions on this form should pertain to the accident you believe is most recent or most important to your symptoms. If you have been in other accidents in the past please provide us with a list of those accidents and the treatment you received for those on the back of this form. Thank You.

Date of Accident ________________________
City ___________________________
Street ___________________________________
Make and Model of your Vehicle. ________________________________
Make and model of other vehicle(s) involved. ______________________________________
How fast was your vehicle moving at the instant of the crash? _____________________
How fast was the other vehicle traveling at the instant of the crash? ________________
Were you the Driver Passenger ?
Were you wearing a seat belt at the time ? Yes No
Does your car have a head rest ? Yes No

Did the accident involve:
Head on collision Rear end Collision Hit from the Side - Which side? Rt. Lt.

Didn't collide with another vehicle Hit stationary object? What? _________________

How much damage was done to your vehicle in dollars? $_________ The other Vehicle $________
Did your seat break? Yes No
Did you hit your head? Yes No
Did you lose consciousness? Yes No
Did you think you were hurt immediately? Yes No
If not, when did you first notice any symptoms? ________________________________
And what were those symptoms? ___________________________________
When did you first notice your current symptoms? ____________________________________
Was anyone else in your vehicle at the time? Yes No
What injuries did they sustain? ____
Were you taken to the hospital? Yes No Which Hospital? __________________________
Did you have X-rays done? Yes No Of What? _________________________________
Any other tests? ____
What were you told was wrong at that time? ____
Did you see any other physicians since then about this? If so please list IN ORDER below?
Doctor Tests Done Treatments Given
____
____
____
____
____

Is there a settlement pending? Yes No Already settled
Do you have an attorney assisting you with the settlement? Yes No
If so please give name, address and Phone here. ____