

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. _____

