



Motor Vehicle Accident History

Name: _____ Date of the accident: _____

Insurance company: _____ Claim number: _____

Adjuster name: _____ Adjuster phone number: _____

Time of accident: _____ [] AM [] PM What state: _____ Who was cited for accident: _____

Was the vehicle a company car? [] YES [] NO Did the accident happen on company time? [] YES [] NO

Your vehicle was a: [] compact [] mid-size [] full-size [] truck [] full truck [] van [] SUV [] other: _____

What were the road conditions at time of accident: _____

Where was your car struck: [] front [] rear [] r-side [] l-side [] r-front corner [] l-front corner

[] r-back corner [] l-back corner [] other: _____

What is the estimated damage to your vehicle: \$ _____ Total loss: [] YES [] NO

You were heading: [] north [] south [] east [] west on: _____ (street or hwy)

Other vehicle was heading: [] north [] south [] east [] west on: _____ (street or hwy)

Please explain in detail how your accident occurred: _____

Number of people in the car including yourself: _____ Your position in the car: [] driver [] passenger

If you were the passenger, which seat were you in: [] front seat right side [] back seat left side

[] back seat right side [] back seat center

How fast was your vehicle moving upon impact: _____ MPH [] stopped

How fast was the other vehicle moving upon impact: _____ MPH [] stopped

Were the brakes applied at time of impact: [] YES [] NO Did the seat break at time of impact: [] YES [] NO

Did the airbags deploy at time of impact: [] YES [] NO Was your seatbelt on at time of impact: [] YES [] NO

Were the police notified: [] YES [] NO Did your head strike the windshield or any objects: [] YES [] NO

Did you feel pain immediately after accident: [] YES [] NO [] later that day [] next day [] other _____

What were your immediate symptoms after the accident: _____

Have you ever had any complaints in the involved area before: [] YES [] NO

Since your injury, are your symptoms: [] improving [] getting worse [] the same

Did you lose consciousness at the time of the accident: [] YES [] NO

Where did you go after the accident: [] work [] home [] hospital [] chiropractor [] family doctor

If you sought medical care, where did you go: _____

If you sought medical care, how did you get there: [] self [] friend [] ambulance [] helicopter