AUTOMOBILE ACCIDENT OR PERSONAL INJURY INFORMATION

Please answer ALL questions that apply to you.

Name_____

Type of accident □ Auto □ Fall □ Other, Explain_____

_____

Date of accident_____ Time of accident_____

Location of accident_____

IF AUTO ACCIDENT

Were you struck from □ Behind □ Front □ Left side □ Right side

Were you a □ Driver □ Pedestrian □ Passenger, front □ Passenger, back

AUTO ACCIDENT AND/OR PERSONAL INJURY

Briefly describe accident including cause(s) and surrounding circumstances_____

_____

_____

Were you taken to the hospital? □ Yes □ No

If yes, Hospital name_____

Explain treatment received_____

Check your injury □ Cuts □ Bruises □ Fractures

Note location of injuries_____

Were you knocked unconscious? □ Yes □ No

What were your symptoms immediately following the accident?_____

_____

Symptoms you have had since?_____

Did you have any of these symptoms prior or been injured in the same areas? □ Yes □ No

Explain_____

_____

Has your past health been good? □ Yes □ No, Explain_____

_____