**AUTO RELATED ACCIDENT**

Date and time of Accident:\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ am \_\_\_ pm, Were you the: \_\_\_ Driver \_\_ Front pass. \_\_ Rear pass

If a traffic violation was issued, to whom was it issued? \_\_\_\_\_\_\_\_\_\_\_Number of people in accident vehicle? \_\_\_\_\_

Did the police come to the accident site? \_\_\_ Yes \_\_\_ No, Was a police report filed? \_\_\_\_ Yes \_\_\_\_ No

Were there any witnesses? \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you wearing your seat belt? \_\_\_\_ Yes \_\_\_\_ No, Was the vehicle equipped with air bags? \_\_\_ Yes \_\_\_ No

Did they inflate? \_\_\_\_ Yes \_\_\_\_ No

In the relation to the base of your skull, where was the headrest? \_\_\_\_ above \_\_\_\_\_ below \_\_\_\_\_ base of skull

What did your vehicle impact? \_\_\_ another vehicle \_\_\_ other? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did any part of your body strike anything in the vehicle? \_\_\_ Yes \_\_\_ No, If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Make and Model of the vehicle you were occupying? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 What was the approx. speed of your vehicle? \_\_\_\_\_\_ In which direction were you headed? \_\_ N \_\_ S \_\_ E \_\_W

Name of location/street on which you were traveling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the impact to your vehicle come from the: \_\_\_ Front \_\_\_ Rear \_\_\_Right side \_\_\_ Left side

During impact, were you facing: \_\_ right \_\_ left \_\_ forward? Were you \_\_ aware of \_\_ surprised by the impact?

If accident vehicle made impact with another vehicle?

Make and model of that other vehicle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Direction the other vehicle was headed? \_\_ N \_\_ S \_\_ E \_\_ W? Speed of other vehicle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In your words, please describe the accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AT FAULT AUTO INSURANCE INFORMATION**

Co. Name and address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group ( Plan, Local or Policy) # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to driver: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth of insured: \_\_\_\_\_\_\_\_\_\_ Insured’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AFTER INJURY**

Did the accident render you unconscious?\_\_\_ Yes \_\_\_ No. If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe how you felt immediately after the accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you gone to a Hospital or seen any other Doctor? \_\_\_ Yes \_\_\_ No

When did you go? \_\_\_ just after the accident \_\_\_ the next day \_\_\_ 2 days plus

How did you get there? \_\_\_\_ Ambulance \_\_\_\_ Private transportation

Name of Hospital and/or Attending Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any treatment you received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were X-rays taken? \_\_\_ Yes \_\_\_ No , Was medication prescribed? \_\_\_ Yes \_\_\_ No

Have you been able to work since this injury? \_\_\_ Yes \_\_\_ No, Is your work restricted as a result of this injury?\_\_\_\_

Indicate **X** the symptoms that are a result of this accident? \_\_ Dizziness \_\_ Difficulty sleeping \_\_ Jaw problems

\_\_ Nausea \_\_ Memory loss \_\_ Irritability \_\_ Arm/shoulder pain \_\_ Back pain \_\_ Back stiffness \_\_ Headaches

\_\_ Fatigue \_\_ Numb hand/fingers \_\_ Lower back pain \_\_ Blurred vision \_\_ Tension \_\_ Chest pain

\_\_ Neck pain \_\_ Neck stiffness\_\_ Buzzing in ear \_\_ Shortness of breath \_\_ Leg pain \_\_ Ears ringing

\_\_ Stomach upset \_\_ Numb feet/toes \_\_ Other? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is your condition getting worse? \_\_ Yes \_\_ No

Indicate your degree of comfort while performing the following activities:

 Comfortable / Uncomfortable / Painful Comfortable / Uncomfortable / Painful

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Lying on back |  |  |  | Sports |  |  |  |
| Lying on side |  |  |  | Working |  |  |  |
| Lying on stomach |  |  |  | Lifting |  |  |  |
| Sitting |  |  |  | Bending |  |  |  |
| Standing |  |  |  | Kneeling |  |  |  |
| Stretching |  |  |  | Pulling |  |  |  |
| Running |  |  |  | Reaching |  |  |  |

**RECOVERY**

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal workday? \_\_\_\_\_\_\_\_\_

Please indicate **X** your daily job duties and any activities which you are occasionally asked to perform:

\_\_ Standing \_\_ Driving \_\_ Operating equipment \_\_ Sitting \_\_ Twisting \_\_ Walking \_\_ Crawling \_\_ Typing

\_\_ Lifting\_\_ Working with arms above your head \_\_ Bending \_\_ Stooping \_\_ Other? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there positions can you work in with minimum physical effort and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior to injury were you capable of working on an equal basis with others your age? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you work with others who can help you with any heavy lifting? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

While in recovery, is there any light duty work you could request? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDITIONAL INSURANCE INFORMATION**

Type of insurance: \_\_\_\_\_\_\_\_\_\_ Co Name & Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Name & Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s SS# \_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.: \_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please remember you are ultimately responsible for your account.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notes: