

PERSONAL INJURY REPORT

Name \_\_\_\_\_

Your Ins. Co. \_\_\_\_\_ Policy # \_\_\_\_\_ Agent's Name \_\_\_\_\_

Driver/Other Vehicle \_\_\_\_\_ Ins. Co. \_\_\_\_\_ Policy # \_\_\_\_\_

Have you retained an attorney? ( ) Yes ( ) No Name \_\_\_\_\_

Police Investigation? ( ) Yes ( ) No If yes which Dept. \_\_\_\_\_

Was a citation issued ( ) Yes ( ) No If yes to whom \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time \_\_\_\_\_ am/pm Road Conditions \_\_\_\_\_

Where were you seated in the vehicle? \_\_\_\_\_

What direction were you headed? ( ) North ( ) South ( ) East ( ) West

on (name of street) \_\_\_\_\_

What direction was other vehicle headed? ( ) North ( ) South ( ) East ( ) West

on (name of street) \_\_\_\_\_

Were you struck from ( ) Behind ( ) Front ( ) Left Side ( ) Right Side

How many impacts did you feel and from which direction? \_\_\_\_\_

Were you ( ) AWARE that you were about to be hit ( ) UNAWARE that you were about to be hit

Were you knocked unconscious? ( ) Yes ( ) No If yes for how long \_\_\_\_\_

What direction were you looking at time of impact? \_\_\_\_\_

What position was your head rest in? ( ) Behind head ( ) Down against seat back

Were you wearing a seat belt? ( ) Yes ( ) No If yes ( ) Lap ( ) Shoulder and Lap ( ) Air Bag

Did any part of your body hit anything inside the car? ( ) Yes ( ) No If yes Describe \_\_\_\_\_

What type of car were you in? \_\_\_\_\_

How fast were you moving at time of impact? \_\_\_\_\_ mph. Was your vehicle ( ) slowing down ( ) accelerating

If stopped was driver's foot on the brake? ( ) Yes ( ) No

What type of car impacted with your vehicle? \_\_\_\_\_

How fast was the other vehicle moving at time of impact? \_\_\_\_\_ mph

Was the other vehicle ( ) slowing down ( ) accelerating

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

\_\_\_\_\_

\_\_\_\_\_

Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, please describe \_\_\_\_\_

\_\_\_\_\_

Please describe how you felt:

DURING the accident \_\_\_\_\_

IMMEDIATELY AFTER the accident \_\_\_\_\_

LATER THAT DAY \_\_\_\_\_

THE NEXT DAY \_\_\_\_\_

CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Loss of smell |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Shortness of breath  | <input type="checkbox"/> Loss of balance    | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Neck Stiff        | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Fatigue            | <input type="checkbox"/> Diarrhea      |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head seems heavy     | <input type="checkbox"/> Depression         | <input type="checkbox"/> Cold Hands    |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Pins/Needles in arms | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Cold Feet     |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Pins/Needles in legs | <input type="checkbox"/> Loss of memory     | <input type="checkbox"/> Upset stomach |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Numbness in Fingers  | <input type="checkbox"/> Ears ringing       | <input type="checkbox"/> Cold sweats   |
| <input type="checkbox"/> Irritability      | <input type="checkbox"/> Numbness in Toes     | <input type="checkbox"/> Face flushed       | <input type="checkbox"/> Fever         |

Symptoms other than above that you are PRESENTLY having \_\_\_\_\_

Since this injury are your symptoms ( ) Improving ( ) Getting worse ( ) Same

Do you have any previous illnesses or congenital (from birth) factors which relate to this case? \_\_\_\_\_

Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe including dates and types of accidents, as well as injuries received \_\_\_\_\_

Where were you taken after this accident? \_\_\_\_\_

Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please list doctors name and address \_\_\_\_\_

What type of treatment did you receive? \_\_\_\_\_

Have you lost time from work as a result of this accident? ( ) Yes ( ) No If yes complete this question.

Last day worked \_\_\_\_\_

Type of employment \_\_\_\_\_

Are you being compensated for time lost from work? ( ) Yes ( ) No If yes state type of compensation you are receiving \_\_\_\_\_

What activities have you had to restricted as a result of this accident? \_\_\_\_\_

Other pertinent information \_\_\_\_\_

Signature

Date