**Auto / Crash Information Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Date and time of crash: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Location of crash:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. What was your position in the vehicle: Driver Passenger Backseat - L C R
4. What was your vehicle type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. What was the other vehicle type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. What was your vehicle doing at the time of the crash?

Stopped at an intersection Stopped at a light Parking Making a right turn

Traveling at constant speed Stopped in traffic Accelerating Making a left turn

1. What was the visibility: Good Fair Poor
2. Road conditions: Icy Wet Sandy / rocky Dry and clear
3. What was your speed: \_\_\_\_\_\_\_\_\_\_ What was their speed: \_\_\_\_\_\_\_\_\_
4. What was the point of impact:

Head on Right Side Right front Right rear

Back end Left side Left front Left rear

1. Was there another collision? Yes / No

If so, what was the point of impact?

Head on Right Side Right front Right rear

Back end Left side Left front Left rear

1. Did you see the accident coming: Y / N
2. Did you brace for impact: Y / N
3. What did you use to brace: Hands Feet Both
4. Did you have your hands on the steering wheel (if driving): Y / N

If so, did you let go at impact: Y / N

1. Did you have your seat belt on: Y / N
2. Did you have the shoulder harness on: Y / N
3. What direction was your head facing at the time of impact: Left Straight forward Right
4. What was the position of your headrest:

No headrest Even with top of head Even with bottom of head Mid neck

1. Did your head hit anything else inside the vehicle: Y / N

If so, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Did you lose consciousness during the accident: Y / N Not sure

If so, for how long: \_\_\_\_\_\_\_\_\_\_\_ Seconds / Minutes / Hours Not sure

1. Do you have any gaps in memory of the day of the accident?
2. Did any other body part hit anything inside the care? Y / N
3. Does your car have Airbags: Y / N

If so, did they deploy: Y / N and which ones: Driver Passenger Side

1. Did the seat bend / break: Y / N
2. Did you feel Dazed / Confused after the accident: Y / N
3. Did you feel nauseated after the crash: Y / N
4. Were there any cuts / bruises / abrasions after the crash: Y / N
5. Immediately after the crash, what were your symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Did the police show up? Y / N

If so, did they fill out an accident report? Y / N

1. Where did you go after the accident: Home Work Hospital ER Private Dr.
2. How did you get there? Drove self Someone else Ambulance Police
3. Have you been to the hospital since: Y / N
   1. What hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. How long after the accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   3. Were you admitted: Y / N
      1. If so, for how long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   4. Were X-Rays taken: Y / N Of what region(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   5. Was a diagnosis given: Y / N What was it: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. How were your symptoms over the next 12 hours from the crash:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Have you taken any medication since and due to the accident: Y / N
   1. If so, what meds: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. What are your symptoms now?
   1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Have you missed any work: Y / N If so, how much: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Was there anyone else in the car with you: Y / N

**Insurance Information**

1. Has there been any damage estimates on the vehicle yet? Y / N

If so, what is damaged and / or estimate? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has the application for medical benefits been filled out yet? Y / N
2. Name and address of insurance company:

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1. Name and Number of Agent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_