



ACCIDENTAL INJURY FORM

NAME _____ DATE _____

Date of Accident _____ Time: ___ am ___ pm Location of Accident _____

AUTO INJURY

Were you: Driver Passenger Pedestrian

Were you struck from: Behind Right Side Left Side Front Parked

Did your car strike others involved: Yes No Undetermined

Did the other car strike yours: Yes No Undetermined

As a result of the Accident, were traffic citations issued to you? Yes No

OTHER

Describe the circumstances of the accident (Be Specific): _____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

- | | | | |
|---------------------------------------|---|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Head Too Heavy | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Ears Ringing | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Other |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste | |

Did you require post-accident hospitalizations? Yes No

Have you lost any days of work? Yes No If Yes, _____ through _____.

INSURANCE INFORMATION

Your Insurance Company _____ Address _____

Other Party's Name _____ Address _____

Other Party's Ins. Co. _____ Address _____

Have you been contacted by an insurance Adjustor regarding this claim Yes No

If yes, name of adjuster _____ Company _____

Do you have an attorney that has advised you in this case: Yes No

If yes, attorney's name _____ Address _____

Signature _____