ACCIDENT INFORMATION:

DATE OF ACCIDENT:	TIME:
WERE YOU THE: ☐ DRIVER ☐ FRONT SEAT PASSENGER ☐ BACK SEAT PASSENGER	
WHAT TYPE OF CAR WERE YOU IN?	WHAT TYPE OF CAR WAS THE OTHER VEHICLE/S?
HOW FAST WAS YOUR CAR TRAVELING?	HOW FAST WAS THE OTHER CAR TRAVELING?
WERE YOU STRUCK FROM: ☐ BEHIND ☐ FRONT ☐ LEFT SIDE ☐ RIGHT SIDE ☐ OTHER ____________	
DAMAGE TO YOUR VEHICLE: ☐ MILD ☐ MODERATE ☐ TOTALED	
WERE YOU KNOCKED UNCONSCIOUS? ☐ NO ☐ YES IF YES, FOR HOW LONG? ____________	
WERE YOU HOSPITALIZED? ☐ NO ☐ YES IF YES WHAT HOSPITAL? ____________	

DID YOU SEE THE ACCIDENT COMING? ☐ NO ☐ YES

WERE YOU BRACED FOR IMPACT? ☐ NO ☐ YES

DID YOU HAVE A SEAT BELT ON? ☐ NO ☐ YES

DOES YOUR VEHICLE HAVE HEAD RESTS? ☐ NO ☐ YES

DID AIR BAGS DEPLOY? ☐ NO ☐ YES

DID THE POLICE SHOW UP TO THE SCENE? ☐ NO ☐ YES

IS THERE AN ACCIDENT REPORT FILLED OUT? ☐ NO ☐ YES (IF YES, PLEASE PROVIDE IT)

ARE THERE PICTURES FROM THIS ACCIDENT? ☐ NO ☐ YES (IF YES PLEASE PROVIDE THEM)

PLEASE DESCRIBE HOW YOU FELT 0 TO 10, 10 BEING THE WORST:

BEFORE THE ACCIDENT: 0 1 2 3 4 5 6 7 8 9 10

IMMEDIATELY AFTER THE ACCIDENT: 0 1 2 3 4 5 6 7 8 9 10

LATER THAT DAY: 0 1 2 3 4 5 6 7 8 9 10

THE NEXT DAY: 0 1 2 3 4 5 6 7 8 9 10