

### Motor Vehicle Accident Intake

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Adjustor's Name and Phone #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Accident Date and Time: \_\_\_\_\_ Place of Accident: \_\_\_\_\_

1) Type of vehicle you were travelling in and your position in the vehicle?

\_\_\_\_\_

2) a) Were you wearing a seatbelt and if so, what type (chest and/or lap)?

\_\_\_\_\_

b) Was there a headrest where you were seated? \_\_\_\_\_

3) Were your brakes on at the time of the accident? Yes \_\_\_\_\_ No \_\_\_\_\_

4) Did you see the accident coming? Yes \_\_\_\_\_ No \_\_\_\_\_

5) Describe briefly what direction your vehicle was hit from.

\_\_\_\_\_

\_\_\_\_\_

6) Describe all the symptoms you experienced immediately after the accident (Please be specific).

\_\_\_\_\_

\_\_\_\_\_

7) Did you receive medical attention immediately after the accident? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please indicate:

Were you hospitalized and if so, where? \_\_\_\_\_

How long was your stay? \_\_\_\_\_

Did you attend your doctor's office? Yes \_\_\_\_\_ No \_\_\_\_\_

Please indicate your doctor's name \_\_\_\_\_

Did you receive any: Imaging (x-rays, MRI, CT)? \_\_\_\_\_ Area \_\_\_\_\_

Medication? \_\_\_\_\_ Name of Medication \_\_\_\_\_

Other types of treatment \_\_\_\_\_

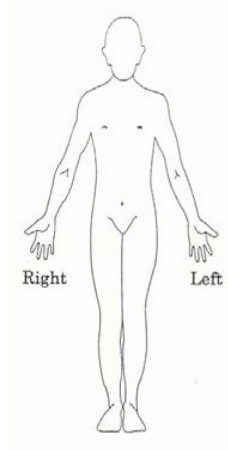
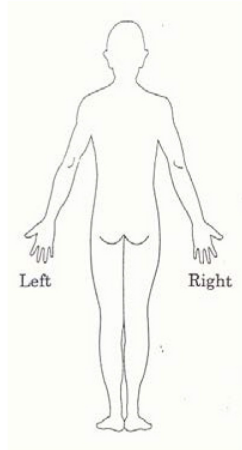
8) a) Describe all symptoms you are experiencing presently?

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b) Please mark the area on the diagram where you were injured



c) Did you have any problems in any of the areas indicated before the accident? If so, where and for how long?

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9) Were you involved in a previous motor vehicle accident and if so, please describe any associated injuries?

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