Center For Life

Accident History

Name____Date______________
Address_________________________City___________St.__________Zip_______
Home Phone_______________DOB______________________SSN_____________

Date/Time of Accident__________________Location_________________________

Please describe the accident:

____

How much damage occurred?____

How fast were you driving?____
If you were hit from behind, how fast was the other vehicle going?_____________

Did you go to the emergency room, or receive any other medical care because of this accident? No____ Yes_____ Please explain: ______________________________

What are your present complaints and symptoms related to the accident? ________

Number of people in your vehicle?_____Were you wearing seatbelts?___________

Signature:____