Form: Personal injury automobile accident case checklist

PERSONAL INJURY AUTOMOBILE ACCIDENT CASE CHECKLIST

Did you witness the accident? Yes _____ No _____

When? _____

Where? _____

How far were you from the accident? _____

Describe the visibility, time of day, weather conditions. _____

Where did the accident happen? _____

Are you familiar with the accident location? Yes _____ No _____

Do you travel there frequently? Yes _____ No _____

Describe the accident location (e.g., 2 lane, 4 lane, flat, hilly). _____

Give me specific identifying items about the accident location:

Which side of the road? Left _____ Right _____

Which direction were the cars heading? North _____ South _____ East _____ West _____

Where were you coming from prior to the accident? _____

Where were you going? _____

What direction were you headed? _____

What direction was the other car headed? _____

Had you anything to drink before getting into the car? Yes _____ No _____

Had you taken any drugs or medication? Yes _____ No _____

Your physical condition. _____

Your mental condition. _____

As you were driving, were you listening to the radio? Yes _____ No _____

Were windows open _____ closed _____

Do you smoke? Yes _____ No _____

Were you lighting a cigarette? Yes _____ No _____

Was there anyone in the car with you? Yes _____ No _____

Were you talking to the person in the car with you? Yes _____ No _____

Was anyone in the back seat of the car? Yes _____ No _____

Were you talking to someone in the back seat of the car? Yes _____ No _____

Was there anything that distracted you when you were driving? Yes _____ No _____

Looking to the left or right? Yes _____ No _____

Were there any witnesses to the accident? Yes _____ No _____

Did you talk to the witnesses to the accident? Yes _____ No _____

Was road surface: Clear _____ Rainy _____ Wet _____ Artificial lighting _____ Street lights _____

Was anything unusual? Yes _____ No _____

What was the color of the vehicle: _____

Were your headlights on? Yes _____ No _____

How fast were you driving? _____

How fast was the other person driving? (Estimate speed) _____

How far were you from the impact when you first saw the other car? _____

Number of feet _____ Speed _____ Time _____

Have the witness estimate the speed, distance, and time prior to the impact.

Did you see the impact? Yes _____ No _____

Did you hear the impact? Yes _____ No _____

How far away were you from the impact? _____

Have the witness complete the accident diagram.

What evasive actions did you take? Sound your horn _____ Apply your brakes _____ Swerve _____

What did you do after the accident? _____

Did you get out of your car? Yes _____ No _____

Who did you talk to? _____

What did you do immediately after you got out of your car? _____

What did the other party do? _____

Did they get out of their car? Yes _____ No _____

Who did they talk to? _____

What did you tell the witnesses? _____

What did you tell the police officer? _____

What did you tell the emergency ambulance people? _____

Did you give a statement to anyone? Yes _____ No _____

Go over their driving record.

Previous tickets _____

Accidents _____

Condition of their vehicle? _____

The other party's vehicle? _____

. Where is the car now? _____

Who did the body work? _____

How much did it cost? $ _____

Review their insurance.

Policy limit amounts in effect. _____

When it expires. _____ [date]

Condition of their car. _____

Other party's car. _____

Any defects, last service, previous accidents on that vehicle, mechanical condition. _____

INJURIES:

Describe your injuries, bruises, bones, places where it hurts. _____

List every problem you have. _____

Did the doctor tell you to stay off work? _____

Emergency treatment. _____

Date, time and place of all medical treatments. _____

Medications. _____

Physical therapy. _____

What did the doctor say? _____

. Prognosis? _____

What conditions have you recovered from? _____

What conditions remain? _____

MEDICAL CONDITION:

Restricted activities. _____

Things you could do before the accident. _____

Things you cannot do after the accident. _____

Pain. _____

Suffering. _____

Have injuries interfered with your abilities to

a. work? Yes _____ No _____

(b) to perform a job? Yes _____ No _____

What activities can you not do as a result of the accident; such as sleep, eat, recreation, sport, household duties, activities with the spouse or children, sexual relationship? _____

MENTAL CONDITION:

Any psychological disorders? Yes _____ No _____

Mental Anguish? Yes _____ No _____

Treatment: _____

Physical problems as a result of mental anguish: _____

Have you applied for social security or disability coverage? Yes _____ No _____

Are you receiving benefits? Yes _____ No _____

Are you receiving worker's compensation payments? Yes _____ No _____

Are you receiving medical insurance? Yes _____ No _____

Have your medical bills been paid for? Yes _____ No _____

Who paid them? _____

Do you support anybody? Children _____ Spouse _____ Parents _____

Have you had to hire anybody to do your work that you cannot do as a result of the accident? Yes _____ No _____

EXPENSES:

Car rental

Out-of-pocket expenses as a result of the accident:

Car rental: $ _____

Drugs: $ _____

Doctor bills: $ _____ **PREVIEW**

Have them produce their tax returns.

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THANK YOU