If yours is an accidental injury, Please complete the information on this page

AUTO / WORK RELATED ACCIDENT

one

ABOUT YOU

Today's Date _____ File #: _____

Name: _____

Birthdate: ____/____/____ Age: _____ SS#: _____

two

AUTO RELATED ACCIDENT

Date & Time of Accident _____ ❑ a.m. ❑ p.m.

Were you the: ❑Driver ❑Front Passenger ❑Rear Passenger

If a traffic violation was issued, to whom was it issued?

_____

Number of people in accident vehicle? _____

Did the police come to the acident site. . . . . ❑ Yes ❑ No

Was a police report filed?. . . . . .❑ Yes ❑ No

Were there any witnesses?. . . . . ❑ Yes ❑ No

Was this vehicle equipped with airbags?. . . .❑ Yes ❑ No

If yes, did it/they inflate?. . . . . ❑ Yes ❑ No

In relation to the base of your skull, where was the headrest?. . . . . .❑ Above ❑ Below ❑ At base of skull

What did your vehicle impact? ❑ Another Vehicle ❑ Other

If other, explain? _____

Did any part of your body strike anything in the vehicle? ❑ Yes ❑ No

If yes, please describe: _____

_____

Make & model of the vehicle you were occupying?

_____

Name of the location/street on which you were traveling?

_____

In wich direction were you headed? ❑ N ❑ S ❑ E ❑ W

What was the approx. speed of your vehicle? _____

Did the impact to your vehicle come from the:

❑ Front ❑ Rear ❑ Right Side ❑ Left Side ❑ Other

During impact, were you facing: ❑ Right ❑ Left ❑ Forward

Were you ❑ aware or ❑ surprised by the impact?

If accident vehicle made impact with another vehicle. . .

Make and model of that other vehicle?

_____

Direction other vehicle was headed? ❑ N ❑ S ❑ E ❑ W

Speed of the other vehicle?

In your words, please describe the accident:

_____

_____

_____

three

WORK RELATED ACCIDENT

Date & Time of Accident _____ ❑ a.m. ❑ p.m.

Was your accident directly related to your work?

❑ Yes ❑ No

Briefly describe the events that occurred just before and during your accident: _____

_____

_____

Give the address where accident occurred? (if other than employer's address) _____

_____

Was anyone else present during your accident?

❑ Yes ❑ No

Did you report your accident to your employer?

❑ Yes ❑ No

What recommendations did your employer make just after your accident? _____

_____

Has this type of accident happened to you before?

❑ Yes ❑ No

To the best of your knowledge, has this accident occurred in your workplace before?. . . . . .❑ Yes ❑ No

In general:

Is your job physically stressful?. . . . . ❑ Yes ❑ No

Is your job mentally stressful?. . . . . ❑ Yes ❑ No

Is your workplace noisy?. . . . . ❑ Yes ❑ No

Have you changed jobs in the past last year?. . . . .❑ Yes ❑ No

please continue on back.

four

Did accident render you unconscious?. . . . . ❑ Yes ❑ No

If yes for how long? _____

Please describe how you felt immediately after the accident:

_____

_____

Have you gone to a Hospital or seen any other Doctor? ❑ Yes ❑ No

When did you go? ❑ Just after the accident ❑ The next day ❑ 2 days plus

How did you get there? ❑ Ambulance or ❑ Private transportation

Name of Hospital and/or Attending doctor: _____

_____

Was he/she a ❑ D.C. ❑ M.D. ❑ D.O. ❑ D.D.S.

Describe any treatment you received: _____

_____

Were x-rays taken?. . . . . ❑ Yes ❑ No

Was medication prescribed?. . . . . ❑ Yes ❑ No

Have you been able to work since this injury?. . . . . ❑ Yes ❑ No

Are your work activities restricted as a result of this injury?

❑ Yes ❑ No

Indicate ☑ the symptoms

❑ Dizziness	❑ Difficulty sleeping	❑ Jaw problems	❑ Nausea
❑ Memory loss	❑ Irritability	❑ Arms/Shoulder pain	❑ Back pain
❑ Headache(s)	❑ Fatigue	❑ Numb Hands/Fingers	❑ Lower back pain
❑ Blurred vision	❑ Tension	❑ Chest pain	❑ Back stiffness
❑ Buzzing in ear	❑ Neck pain	❑ Shortness of breath	❑ Leg pain
❑ Ears ringing	❑ Neck stiff	❑ Stomach upset	❑ Numb Feet/Toes

❑ Other _____

Is your condition getting worse?

❑ Yes ❑ No ❑ Constant ❑ Comes & goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable (even if only sometimes)	Painful
Lying on back	❑	❑	❑
Lying on side	❑	❑	❑
Lying on stomache	❑	❑	❑
Sitting	❑	❑	❑
Standing	❑	❑	❑
Stretching	❑	❑	❑
Lovemaking	❑	❑	❑
Walking	❑	❑	❑
Running	❑	❑	❑
Sports	❑	❑	❑
Working	❑	❑	❑
Lifting	❑	❑	❑
Bending	❑	❑	❑
Kneeling	❑	❑	❑
Pulling	❑	❑	❑
Reaching	❑	❑	❑

Have you retained and attorney: ❑ Yes ❑ No

If yes, whom: _____

His/Her Phone#: _____

five

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in you normal work day?

Please indicate ☑ your daily job duties and any activities which you are occasionally asked to perform.

❑ Standing	❑ Driving	❑ Operating equipment
❑ Sitting	❑ Twisting	❑ Work with arms above head
❑ Walking	❑ Crawling	❑ Typing
❑ Lifting	❑ Bending	❑ Stooping

❑ Other _____

What positions can you work in with minimum physical effort and for how long? _____ ❑ N/A

Prior to the injury were you capable of working on an equal basis with others your age? ❑ Yes ❑ No ❑ N/A

Do you work with others who can help you with any heavy lifting? ❑ Yes ❑ No ❑ N/A

While in recovery, is there any light duty work you could request? ❑ Yes ❑ No ❑ N/A

six

ADDITIONAL INSURANCE

2nd Insurance Source or Auto Insurance

Type of Insurance: _____

Co. Name: _____

Address: _____

Phone #: _____

Insured's Name: _____

Policy #: _____ Claim #: _____

Insured's SS #: _____ D.O.B. _____

Insured's Employer: _____

Agent's Name: _____

If any of your medical or account information has changed, please inform our front desk personnel.

Please remember you are ultimately responsible for your account.

_____

SIGNATURE DATE

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

_____

_____