AUTO / WORK RELATED ACCIDENT

one

ABOUT YOU

Today's Date: _____/_____/_____

Name: _____
Height:_____ Weight: _____
Age: _____
Are you: □ Right or □ Left Handed or □ Both?

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WORK RELATED ACCIDENT *ONLY*

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 you job physically stressful? .....□ Yes □ No
Is your job mentally stressful?.....□ Yes □ No
Is your workplace noisy? .....□ Yes □ No
Have you changed jobs in the last year? …□ Yes □ No

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AUTO RELATED ACCIDENT ONLY

Date of Accident: _____ Time:_____
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 accident site?.....□ Yes □ No
Was a police report filed?.....□ Yes □ No
Were there any witnesses?.....□ Yes □ No
Were you wearing your seat belt?.....□ 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? _____

_____

In which state did the accident occur? _____
In which city and street did the accident occur?_____

_____

In which 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: _____

_____

_____

_____

_____

PLEASE CONTINUE ON BACK

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AFTER INJURY

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 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 that are a result of this accident:

□ Dizziness	□ Fatigue	□ Difficulty Sleeping	□ Buzzing in Ear
□ Headache(s)	□ Irritability	□ Arms/Shoulder pain	□ Back Pain
□ Tension	□ Blurred vision	□ Numb Hands/Fingers	□ Back Stiffness
□ Neck Pain	□ Ears ringing	□ Numb Feet/Toes	□ Jaw Problems
□ Neck Stiff	□ Nausea	□ Lower Back Pain	□ Memory Loss
□ Chest Pain	□ Leg Pain	□ Shortness of Breath	□ Stomach upset

Other _____

Is your condition getting worse?
□ Yes □ No □ Constant □ Comes & goes

Indicate your degree of comfort while performing the following activities:

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

Have you retained an attorney: □ Yes □ No

If yes, whom: _____

His/Her Phone #: _____

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RECOVERY

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

How many hours are in your 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

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ADDITIONAL INSURANCE

2nd Insurance Source or Auto Insurance

Type of Insurance: _____

Co. Name: _____

Address: _____

Phone #: _____

Insured's Name: _____

Claim #: _____

Policy #: _____

Insured's SS #: _____ DOB: ___/___/___

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