AUTO / WORK RELATED ACCIDENT

one — ABOUT YOU

Today's Date: ___/___/___ File #: ____________

Name: ____________

two a — 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 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?

____

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

____

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: ____________

____

____

____

two b — 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 last year? ❑ Yes ❑ No

PLEASE CONTINUE ON BACK

three

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	❑ 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 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 #: __________

four

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

five

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

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PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET