Auto/Work
Related Accident

About You…

Name_____ File # _____ Today's Date_____

Auto Related Accident

Date and Time of Accident: _____ □ am □ pm
Were you the: □ Driver □ Front Passenger □ Rear Passenger
If a traffic violation was issued, to whom was it issued? _____
Number of people in the 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 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 and 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 approximate speed of your vehicle? _____
Did the impact of your vehicle come from the: □ Front □ Rear □ Right Side □ Left Side □ Other
During impact were you facing: □ Right □ Left □ Forward
Were you: □ Aware of or □ Surprised by the impact?
If accident vehicle made impact with another vehicle…

Make and model of the other vehicle_____
Speed of the other vehicle_____
Direction the other vehicle was headed: □ N □ S □ E □ W
In your words, please describe the accident. _____
_____

Work Related Accident

Date and Time of Accident: _____ □ am □ pm
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? _____
_____

Work Related Accident cont'd…

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

After Injury

Did the 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 doctors? ☐ 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 medicine 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
☐ Irritability	☐ Memory loss	☐ Arms/shoulder pain	☐ Back pain
☐ Headache(s)	☐ Fatigue	☐ Numb hands/fingers	☐ Lower back pain
☐ Tension	☐ Blurred vision	☐ Chest pain	☐ Back stiffness
☐ Neck pain	☐ Buzzing in ear	☐ Shortness of breath	☐ Leg pain
☐ Ears ringing	☐ Neck stiff	☐ Stomach upset	☐ Numb feet/toes

☐ Other _____

Is your condition getting worse? ☐ yes ☐ no ☐ constant ☐ comes and goes

Indicate your level of comfort while doing the following activities:

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

Have you retained an attorney? ☐ yes ☐ no
If yes, whom: _____
His/Her phone number: _____

Recovery

To evaluate the effect that continuing work will have on your recovery please complete the following:
How many hours are in your normal workday? _____

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

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

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.

X_____
Signature Date