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AUTO / WORK RELATED ACCIDENT

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ABOUT YOU

Today's Date: ____ / ____ / ____ File #: _____

Name: _____

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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

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: _____

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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 ☐ 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 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: _____

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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