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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? \_\_\_\_\_

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: \_\_\_\_\_

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:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Dizziness      | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Jaw problems        | <input type="checkbox"/> Nausea          |
| <input type="checkbox"/> Memory loss    | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Arms/Shoulder pain  | <input type="checkbox"/> Back pain       |
| <input type="checkbox"/> Headache(s)    | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Numb Hands/Fingers  | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Tension             | <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Back stiffness  |
| <input type="checkbox"/> Buzzing in ear | <input type="checkbox"/> Neck pain           | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Leg pain        |
| <input type="checkbox"/> Ears ringing   | <input type="checkbox"/> Neck stiff          | <input type="checkbox"/> Stomach upset       | <input type="checkbox"/> Numb Feet/Toes  |
| <input type="checkbox"/> Other _____    |  |  |  |

Is your condition getting worse?

☐ Yes ☐ No ☐ Constant ☐ Comes & goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable <small>even if only sometimes</small>	Painful
Lying on back . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on stomach . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lovemaking . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.

- |                                   |                                   |  |
|-----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Standing | <input type="checkbox"/> Driving  | <input type="checkbox"/> Operating equipment       |
| <input type="checkbox"/> Sitting  | <input type="checkbox"/> Twisting | <input type="checkbox"/> Work with arms above head |
| <input type="checkbox"/> Walking  | <input type="checkbox"/> Crawling | <input type="checkbox"/> Typing                    |
| <input type="checkbox"/> Lifting  | <input type="checkbox"/> Bending  | <input type="checkbox"/> Stooing                   |

☐ 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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