

# 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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     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 <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 #: \_\_\_\_\_

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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     Stoopng
- 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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