AUTO/WORK RELATED ACCIDENT

AUTO/WORK RELATED ACCIDENT

1 one

ABOUT YOU

Today's Date: ___/___/___ File #:_________
Name: ________________________________

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AUTO RELATED ACCIDENT

Date & 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 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 a seatbelt? …………...__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? __
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 of your vehicle come from the:
☐Front ☐Rear ☐Right Side ☐Left Side ☐Other
During the 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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WORK RELATED ACCIDENT

Date & Time of Accident:________ ☐ AM ☐ PM
Was your accident directly related to 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

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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 Doctor?
___ Yes ___ No
When did you go? _Just after the accident _ The next day _2 days plus
How did you get there? __Ambulance __Private Transportation
Name of Hospital and/or Attending doctor: _______________
____
Was he/she a: __D.C. __M.C __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 _ Arms/Shoulder pain _ Nausea _ Jaw problems
_ Memory loss _ Irritability _ Difficulty Sleeping _ Lower back pain
_ Headache(s) _ Chest pain _ Fatigue _ Back pain
_ Blurred Vision _ Tension _ Numb Hands/Fingers _ 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 #: ______________________________

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

__ Standing __ Driving __ Operating Equipment
__ Sitting __ Twisting __ Work w/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 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

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY
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