

AUTO/WORK INJURY

PERSONAL INFORMATION

NAME: _____

AUTO RELATED ACCIDENT

Date/time of accident: _____ a.m. p.m.

Were you the Driver Front Passenger Rear Passenger

If traffic violation was issued, to whom was it issued? _____

Number of people in accident vehicle _____

Did 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 they inflate? Yes No

In relation to the base of your skull, where was the head rest?

Above Below At base of skull

What did you vehicle impact? Another vehicle

Other (explain) _____

Did any part of your body strike anything in the vehicle?

Explain _____

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 approximate speed of your vehicle? _____

Impact come from Front Rear Right Left Other

During the impact were you facing Right Left Forward

Were you aware or suprised by the impact?

If accident vehicle made impact with another vehicle...

Make & Model of other vehicle _____

Direction other vehicle was headed N S E W

Speed of other vehicle _____

In your words please describe the accident: _____

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 the accident occurred (if other than

your 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

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? Just after accident 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.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 discomfort while performing the following activities:

	Comfortable	Uncomfortable	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? _____

Attorney Phone # _____

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 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 heavy lifting?
 Yes No N/A

During recovery, is there any light duty work you can request?
 Yes No N/A

ADDITIONAL INSURANCE

2nd Insurance Source of Auto Insurance

Type of Insurance: _____

Insurance Company: _____

Address: _____

Phone #: _____

Insured's Name: _____

Policy #: _____ Claim #: _____

Insured SSN: _____ 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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