AUTO / WORK RELATED ACCIDENT

ABOUT YOU

Today's Date: _____ File #: _____ Name: _____

AUTO RELATED ACCIDENT

Date & Time of Accident: _____ Where you the: ◯ Driver ◯ Front Passenger ◯ Rear Passenger

If a traffic violation was issued, to whom was it issued? _____ Number of people in 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 the vehicle equipped with airbags? ◯ Yes ◯ No If yes, did they inflate? ◯ Yes ◯ No

In relation to the base of your skull, where was the headrest? ◯ Above ◯ Below ◯ At the base of the skull

What did your vehicle impact? ◯ Another vehicle ◯ Other If other, please explain: _____

Did any part of your body strike anything in the vehicle? ◯ Yes ◯ No If yes, what? _____

Make & Model of vehicle: _____ Where did the accident take place? _____

In which direction were you headed? ☐ North ☐ South ☐ East ☐ West What was the speed of the vehicle? _____

The impact to the 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 the accident vehicle made impact with another vehicle...

Make & model of the 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: _____ Was your accident directly related to your work? ◯ Yes ◯ No

Briefly Describe the events that occurred just before and during your accident:

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 workplace noisy? ◯ Yes ◯ No

Is your job mentally stressful? ◯ 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 did you go? ◯ Just after accident ◯ The next day ◯ 2 days + How did you get there? ◯ Ambulance ◯ Other

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 Are your work activities restricted as a result of this injury? ◯ Yes ◯ No

Was medication prescribed? ◯ Yes ◯ No Have you been able to work since this injury? ◯ Yes ◯ No

Please indicate all the symptoms that are a result of this accident (check all that apply):

☐ 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 stiffness	☐ 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
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 Number:

_____

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 (check all that apply):

- ☐ Standing
- ☐ Lifting
- ☐ Crawling
- ☐ Work with arms above head
- ☐ Sitting
- ☐ Driving
- ☐ Bending
- ☐ typing
- ☐ Walking
- ☐ Twisting
- ☐ Operating Equipment
- ☐ Stopping
- ☐ Other _____

What position can you work in with minimal physical effort and for how long? _____

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 other 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

ADDITIONAL INSURANCE

2nd insurance source or auto insurace

Type of Insurance: _____ Company Name: _____

Address: _____ Phone Number: _____

Insured's Name: _____ Policy Number: _____

Claim Number: _____ Insured's SSN: _____ Insured's 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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