

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 the 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 to 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 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 head-rest?..... 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 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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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"/> Backpain |
| <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 |

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	<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 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"/> 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's SS #: _____ D.O.B. ___/___/___

Insured's Employer: _____

Agent's Name: _____

If any of your medical 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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