

# AUTO / WORK RELATED ACCIDENT

*1*  
**one**

*2a*  
**twoa**

**ABOUT YOU**

Today's Date: \_\_\_ / \_\_\_ / \_\_\_ File #: \_\_\_\_\_  
 Name: \_\_\_\_\_

**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?  
 \_\_\_\_\_

*2b*  
**twob**

**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

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

# three

## 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"/> Back pain       |
| <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  |
| <input type="checkbox"/> 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 #: \_\_\_\_\_

# four

## 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.

- |                                   |                                   |  |
|-----------------------------------|-----------------------------------|--|
| <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"/> 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

# five

## 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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