

**PLEASE COMPLETE THE FOLLOWING FOR ANY INJURIES / ACCIDENTS**

Accident/Injury date \_\_\_\_\_ Hour \_\_\_\_\_ 9 AM 9 PM Location \_\_\_\_\_

Accident/Injury caused by: 9 Auto Accident 9 On-the-Job Injury 9 Sports 9 Home Other \_\_\_\_\_

Describe the circumstances of the Accident/Injury \_\_\_\_\_

\_\_\_\_\_

Did you report the injury to your Foreman or Employer? 9 Yes 9 No Person's Name \_\_\_\_\_

Did he/she recommend care and treatment at our office? 9 Yes 9 No

If **Auto Accident**, were you: 9 Driver 9 Passenger = 9 Front 9 Rear seat; Wearing seat belt? 9 Yes 9 No; 9 Pedestrian

Were you struck from: 9 Behind 9 Right Side 9 Left Side 9 Front; Auto was 9 Parked / 9 Stopped at the time

Did your auto strike the other(s)? 9 Yes 9 No, Or, did the other auto strike yours? 9 Yes 9 No; 9 Undetermined

Were traffic citations issued to you? 9 Yes 9 No To the driver of the other car? 9 Yes 9 No To the driver of

your car? 9 Yes 9 No Was the accident reported to the Police and was a Police Report made? 9 Yes 9 No

List the extent of **your injuries** as you know them \_\_\_\_\_

\_\_\_\_\_

Did you require any post-accident hospitalization? 9 Yes 9 No Location / How long? \_\_\_\_\_

Did you obtain any Emergency Care/Treatment? 9 Yes 9 No Location \_\_\_\_\_

Check **ANY** and **ALL** symptoms that you have noticed as a result of the accident/injury:

- |  |  |  |  |  |
|--|--|--|--|--|
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Pins & Needles in Arms    | <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Face Flushed    | <input type="checkbox"/> Feet Cold     |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Numbness in Fingers       | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold    |
| <input type="checkbox"/> Neck Stiffness    | <input type="checkbox"/> Pins & Needles in Legs    | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Nausea          | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Numbness in Legs/Toes     | <input type="checkbox"/> Depression          | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Constipation  |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Irritability/Tension      | <input type="checkbox"/> Lights Bother Eyes  | <input type="checkbox"/> Loss of Smell   | <input type="checkbox"/> Cold Sweats   |
| <input type="checkbox"/> Leg pain/Sciatica | <input type="checkbox"/> Dizziness/Loss of Balance | <input type="checkbox"/> Loss of Memory      | <input type="checkbox"/> Loss of Taste   | <input type="checkbox"/> Fever         |
| <input type="checkbox"/> Shoulder/Arm Pain | <input type="checkbox"/> Head Seems Too Heavy      | <input type="checkbox"/> Ringing in Ears     | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Muscle Cramps |

List any symptoms other than above \_\_\_\_\_

Were you having any problems **before** this Accident/Injury? 9 Yes 9 No Describe \_\_\_\_\_

Have you lost any days of work? 9 Yes 9 No Dates \_\_\_\_\_ Date returned to work \_\_\_\_\_

If working, are you on 9 Regular Duty 9 Light/Modified Duty - For how long? \_\_\_\_\_

**Insurance Companies** involved:

Your Company \_\_\_\_\_ Address \_\_\_\_\_

Other Person's \_\_\_\_\_ Address \_\_\_\_\_

Have you been contacted by an Insurance Adjuster or Company Representative regarding this claim? 9 Yes 9 No Person's Name \_\_\_\_\_

Have you obtained an Attorney regarding this case? 9 Yes 9 No Will you be obtaining an Attorney? 9 Yes 9 No

Attorney's Name \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**Patient's signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent, Guardian or Spouse's signature** \_\_\_\_\_ **Date** \_\_\_\_\_