

ACCIDENTAL INJURY REPORT

Name _____ Today's Date _____ Date of Accident _____ Time of Accident _____

Location of accident _____

Type of Accident Auto/Traffic Work/On Job At home Other _____

Describe how the accident happened in your own words: _____

Immediately following the accident, how did you feel? _____

How did you feel the next day? _____

Were you unconscious? Yes No In a daze? Yes No Did you go to the hospital? Yes No

If you went to the hospital, when? At the time of accident Next Day Other _____

If you went to the hospital, how did you get there? Ambulance Private Transportation

Did the ambulance attendants place you in any of the following: Neck Collar Splint Brace

Name of the Hospital _____ Attending Physician _____

Were you X-Rayed at the Hospital? Yes No If so, what was the diagnosis? _____

Were you admitted to the Hospital? Yes No If so, how long did you stay? _____

What treatment was rendered? _____

What recommendations were made? _____

List any other doctors you have seen as a result of this accident _____

Have you lost any time from work because of this accident? Yes No If so, give dates of disability _____

Have you returned to work since the accident? Yes No

Date	Employer	Occupation	Light Duty/Regular Duty	Full Time/Part Time
_____	_____	_____	Light Duty/Regular Duty	Full Time/Part Time
_____	_____	_____	Light Duty/Regular Duty	Full Time/Part Time
_____	_____	_____	Light Duty/Regular Duty	Full Time/Part Time
_____	_____	_____	Light Duty/Regular Duty	Full Time/Part Time

Since the accident occurred, are your symptoms: Improving Getting worse Same

Do you notice any activity restrictions as a result of this injury? Yes No If yes, describe _____

Have you been contacted by an insurance adjuster or company representative about this accident? Yes No

If so, name, phone number of person contacting you: _____

Have you retained an attorney? Yes No Date attorney retained or to be retained: _____

Attorney's name _____ Phone Number _____

Address _____

City _____ State _____ Zip _____

Are there any witnesses? Yes No

Other pertinent information: _____

Patient Signature _____
Date

Please complete the questions on the back side in the category of accident you had.

Auto/Traffic Accident

Was the accident reported to the police? Yes No Number of people in your car? _____
 Were traffic citations issued to You Driver of your car Driver of the other car None
 Were you a Driver Passenger Pedestrian
 If passenger, where were you sitting? Front Right Rear Left Rear
 Type of car Truck Motorcycle Car Other
 Did your vehicle hit other vehicle(s)? Yes No Estimated Rate of Speed _____ MPH
 Was your vehicle hit by other vehicle(s)? Yes No Estimated Rate of Speed _____ MPH
 What kind of vehicle hit yours Truck Motorcycle Car Other
 Was the impact from? Front Right Side Left Side Rear
 Were you wearing a seatbelt? Yes No Did you strike anything in the vehicle upon impact? Yes No
 If yes, specify? Steering wheel Dashboard Windshield Side door Arm Rests Side Window
 Please state part of the body Chest Chin Knee Shoulder Hand Head Other _____

VEHICLE YOU WERE IN:
 Driver _____
 Insured _____
 Address _____
 Phone _____
 Auto Insurance _____
 Ins. Co. Address _____
 Adjustor _____
 Phone _____
 Policy Number _____
 Claim Number _____

OTHER VEHICLE:
 Driver _____
 Insured _____
 Address _____
 Phone _____
 Auto Insurance _____
 Ins. Co. Address _____
 Adjustor _____
 Phone _____
 Policy Number _____
 Claim Number _____

Have you been contacted by a representative of the insurance company? Yes No
 Date contacted _____ By _____ Insurance Company _____
 Your Insurance agent's name/ phone number _____
 Have you contacted your insurance company? _____

Work/On Job Accident

List any equipment, machinery and/or object related to the accident: _____
 Was the accident reported to a supervisor or employer? Yes No If so, who _____
 Has a Worker's Compensation claim been filed? Yes No Insurance Carrier _____
 Name and Office Phone of your immediate supervisor/foreman _____
 Type of work being done at the time of injury _____
 Length of time you have worked there prior to accident _____ Have you been injured before? Yes No
 Job Title/Activity _____

In a typical 8 hour day I (circle the hours/activity)

Sit: 1 2 3 4 5 6 7 8 hours	Stand: 1 2 3 4 5 6 7 8 hours	Walk: 1 2 3 4 5 6 7 8 hours	Lift: 1 2 3 4 5 6 7 8 hours	
On the job I perform	Not At All	Occasionally	Frequently	Continuously
Bend/Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach over head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Push/Pull	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I lift up to				
10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient's Signature _____ Date _____