# AUTO / WORK RELATED ACCIDENT

one

two a

## 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 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

## 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?

_____

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

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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:

| | | | |
|---|---|---|---|
| ❑ 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 stiff | ❑ 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 even if only sometimes | 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 #: _____

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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 you are occasionally asked to perform.

| | | |
|---|---|---|
| ❑ Standing | ❑ Driving | ❑ Operating equipment |
| ❑ Sitting | ❑ Twisting | ❑ Work with arms above head |
| ❑ Walking | ❑ Crawling | ❑ Typing |
| ❑ Lifting | ❑ Bending | ❑ 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 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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PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET