

# Accidental Injury Information

\_\_\_\_\_  
(Print) Last Name      First Name      MI      Sex      Age      / /  
\_\_\_\_\_  
DOB

\_\_\_\_\_  
Address      City      State      Zip      Home Phone

\_\_\_\_\_  
Employer      Work Phone      Other Phone

\_\_\_\_\_  
Social Security Number      Marital Status:    **S**    **M**    **W**    **D**

## Accident Information:

Type of accident: \_\_\_\_\_ Auto/traffic    \_\_\_\_\_ Work/On Job    \_\_\_\_\_ At Home    Other \_\_\_\_\_

\_\_\_\_\_  
Date of Accident      \_\_\_\_\_  
Time of accident      **Dry**    **Wet**    **Icy**    **Clear**    **Other**  
Weather Conditions

Briefly describe what happened: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 time of accident?  Yes  No    Next Day?  Yes  No    Other \_\_\_\_\_  
How did you get to the hospital? Ambulance  Yes  No    Private Transportation  Yes  No  
Did the ambulance attendants place you in: Neck Collar  Yes  No    Splints  Yes  No    Brace  Yes  No  
Were you in the hospital for an extended period of time?  Yes  No    If yes, how long was your stay? \_\_\_\_\_  
Name of Hospital \_\_\_\_\_ Attended by Dr. \_\_\_\_\_  
Were you x-rayed at hospital?  Yes  No    If yes, what was the diagnosis? \_\_\_\_\_

\_\_\_\_\_  
Patient Signature (or parent if minor)      \_\_\_\_\_  
Date

Were you x-rayed at hospital?  Yes  No If yes, what was the diagnosis? \_\_\_\_\_

What recommendations were made? \_\_\_\_\_

What treatment was rendered? \_\_\_\_\_

List any other doctors that you have seen as a result of this accident: \_\_\_\_\_

Have you lost any time from work because of this accident?  Yes  No If yes, give dates of disability: (next line)

Totally disabled from \_\_\_\_\_ to \_\_\_\_\_ Partially Disabled from \_\_\_\_\_ to \_\_\_\_\_

Have you returned to work since the accident?  Yes  No Please complete the following:

Date	Employer	Occupation	Light duty/Reg. Duty	Full/part time
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Do you notice any activity restrictions as a result of this injury?  Yes  No Please Describe: \_\_\_\_\_

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

If so, please give name and phone # of person contacting you: \_\_\_\_\_

Name of insurance company: \_\_\_\_\_

Have you contacted your insurance company?  Yes  No

Have you retained an attorney?  Yes  No Date attorney retained or being retained: \_\_\_\_\_

Attorney's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Were there any witnesses?  Yes  No If yes, please list their names: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature (or parent if minor)

\_\_\_\_\_  
Date

## Vehicle Accident Information

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Auto/Traffic Accident

Was the accident reported to the police department?  Yes  No      Number of people in car \_\_\_\_\_

Were traffic citations issued to:  You  Driver of your car  Driver of other car  Other \_\_\_\_\_

Were you the:  Driver  Front Passenger  Rear Passenger  Pedestrian

Did your vehicle hit other vehicle(s)?  Yes  No      Estimated speed of your vehicle at impact? \_\_\_\_\_ MPH

Was your vehicle hit by other vehicle(s)?  Yes  No      Estimated speed of other vehicle at impact? \_\_\_\_\_ MPH

What type of vehicle were you in?  Car  Truck  Motorcycle  Other \_\_\_\_\_

What type of vehicle did you collide with?  Car  Truck  Motorcycle  Other \_\_\_\_\_

Were you struck from:  Behind?  Right Side?  Left Side?  Front?

Were both hands on the steering wheel?  Yes  No

If no, which hand was on the wheel?  Right  Left  Neither

Was your foot on the brake?  Yes  No

Were you:  Surprised by the impact?  Braced for the impact?

Were you wearing a seatbelt?  Yes  No

Did you strike anything at the time of impact?  Yes  No

If yes, specify:  Steering Wheel  Dashboard  Windshield  Side Door  Arm Rest  Side Window

Please state which part of body: \_\_\_\_\_

### Vehicle You Were In

Driver _____
Insured _____
Address _____
Phone _____
Auto Insurance Co. _____
Ins. Co. Address _____
Adjuster _____
Phone _____
Policy # _____
Claim # _____

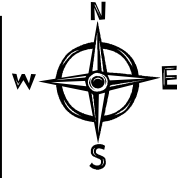
### Other Vehicle

Driver _____
Insured _____
Address _____
Phone _____
Auto Insurance Co. _____
Ins. Co. Address _____
Adjuster _____
Phone _____
Policy # _____
Claim # _____

\_\_\_\_\_  
Patient Signature (or parent if minor)

\_\_\_\_\_  
Date

**Please indicate on the diagram below what happened at the time of the motor vehicle accident.**



At the time of impact, were you:

- Looking straight ahead?
- Looking to the left?
- Looking up?
- Looking to the right?
- Looking down?

**Symptoms/Injuries:**

Check symptoms you have noticed since the accident:

- |                                      |  |   |  |
|--------------------------------------|--|---|--|
| <input type="radio"/> Headaches      | <input type="radio"/> Neck Pain            | <input type="radio"/> Chest Pain          | <input type="radio"/> Dizziness        |
| <input type="radio"/> Memory Loss    | <input type="radio"/> Neck Stiffness       | <input type="radio"/> Shortness of Breath | <input type="radio"/> Fatigue          |
| <input type="radio"/> Vision Blurred | <input type="radio"/> Arm/Shoulder Pain    | <input type="radio"/> Stomach Upset       | <input type="radio"/> Irritability     |
| <input type="radio"/> Ear Buzzing    | <input type="radio"/> Hand/Finger Numbness | <input type="radio"/> Nausea              | <input type="radio"/> Sleep Difficulty |
| <input type="radio"/> Ear Ringing    | <input type="radio"/> Back Pain            | <input type="radio"/> Leg Pain            | <input type="radio"/> Tension          |
| <input type="radio"/> Jaw Problems   | <input type="radio"/> Back Stiffness       | <input type="radio"/> Feet/Toe Numbness   | <input type="radio"/> Depression       |

Symptoms not listed above: \_\_\_\_\_

Is your condition:     Improving                       Staying the same                       Getting worse

Are your symptoms constant or do they come and go? \_\_\_\_\_

How would you best describe the pain?

- |                              |                                 |                                 |                                   |
|------------------------------|---------------------------------|---------------------------------|-----------------------------------|
| <input type="radio"/> Sharp  | <input type="radio"/> Dull      | <input type="radio"/> Throbbing | <input type="radio"/> Numbness    |
| <input type="radio"/> Aching | <input type="radio"/> Shooting  | <input type="radio"/> Burning   | <input type="radio"/> Tingling    |
| <input type="radio"/> Cramps | <input type="radio"/> Stiffness | <input type="radio"/> Swelling  | <input type="radio"/> Other _____ |

Rate Level of Discomfort:     Absent                       Mild                       Moderate                       Extreme

\_\_\_\_\_  
Patient Signature (or parent if minor)

\_\_\_\_\_  
Date

# Work/On Job Accident Information

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

List any equipment, machinery and/or object related to this accident: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Was the accident reported to the supervisor or employer?  Yes  No If so, to whom? \_\_\_\_\_

\_\_\_\_\_  
Has a worker's compensation claim been filed?  Yes  No Insurance carrier: \_\_\_\_\_

Name of your immediate supervisor/foreman: \_\_\_\_\_

Type of work being done at time of injury: \_\_\_\_\_

\_\_\_\_\_  
Length of time you have worked there prior to the injury: \_\_\_\_\_ Have you been injured before:  Yes  No  
Job title/Activity: \_\_\_\_\_

In a typical 8-hour work day, I (circle # of 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

On the job, I perform: Not at all Occasionally Frequently Continuously

Bend/stoop ( ) ( ) ( ) ( )

Squat ( ) ( ) ( ) ( )

Crawl ( ) ( ) ( ) ( )

Climb ( ) ( ) ( ) ( )

Reach above head ( ) ( ) ( ) ( )

Kneel ( ) ( ) ( ) ( )

Push/Pull ( ) ( ) ( ) ( )

I lift up to:

10 lbs ( ) ( ) ( ) ( )

25 lbs ( ) ( ) ( ) ( )

50 lbs ( ) ( ) ( ) ( )

\_\_\_\_\_  
Patient Signature (or parent if minor)

\_\_\_\_\_  
Date