Patient File # ________________

AUTO/WORK RELATED ACCIDENT

Your Name: ____ Today's Date: ____ /_____/_____
LAST FIRST MI

One A

Work Related Accident

Date & Time of Accident: ____ am pm

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 the accident occurred: (if other than employer's address) ____________________________

____

Was anyone 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

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Auto Related Accident

Date & Time of Accident: ____ am pm

Were you the: Driver Front Passenger Rear Passenger Number of people in accident vehicle? __________

If a traffic violation was issued, to whom was it issued? ____

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, please explain: _______________________________

____

Did any part of your body strike anything in the vehicle? Yes No If yes, please describe: _______________________

____

Make and model of the vehicle you were occupying: ____

Name of the location/street on which you were traveling: ____

What was the approximate 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?

Make and model of that other vehicle: ____

Direction other vehicle was headed: North South East West Speed of the other vehicle? _________

In your words, please describe the accident: ____

____

____

____

____

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Two

After Injury

Did you lose consciousness? 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 the accident The next day Two days plus

How did you get there? Ambulance or Private Transportation

Name of Hospital and/or attending Doctor: ____

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
Back Pain	Arms/Shoulder plain	Numb Feet/Toes	Fatigue	Lower back pain	Tension
Blurred Vision	Numb Hands/Fingers	Chest pain	Neck Pain	Buzzing in ear	Leg pain
Ears ringing	Shortness of breath	Back Stiffness	Neck Stiff	Stomach Upset	Headaches

Other ____

Is your condition getting worse? Yes No Constant Comes and goes

Indicate your degree of comfort while performing the following activities:

Lying on back:	Comfortable	Uncomfortable	Painful
Lying on side:	Comfortable	Uncomfortable	Painful
Lifting:	Comfortable	Uncomfortable	Painful
Lying on stomach:	Comfortable	Uncomfortable	Painful
Bending:	Comfortable	Uncomfortable	Painful
Sitting:	Comfortable	Uncomfortable	Painful
Standing:	Comfortable	Uncomfortable	Painful
Walking:	Comfortable	Uncomfortable	Painful

Have you retained an attorney? Yes No

If yes, whom?____________________________________

His/Her Phone #: _________________________________

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Three

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? ______________________________

Do you work with others who can help you with any heavy lifting? Yes No

While in recovery, is there any light duty work you could request? Yes No

Four

Additional insurance

2nd Insurance Source or Auto Insurance

Type of Insurance: ______________________________

Insurance Name: ______________________________ Phone #: ______________________________

Address: ____

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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