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AUTO / WORK RELATED ACCIDENT

2a

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:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Memory loss | <input type="checkbox"/> Irritability | <input type="checkbox"/> Arms/Shoulder pain | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Headache(s) | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numb Hands/Fingers | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Tension | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Back stiffness |
| <input type="checkbox"/> Buzzing in ear | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Leg pain |
| <input type="checkbox"/> Ears ringing | <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Stomach upset | <input type="checkbox"/> Numb Feet/Toes |
| <input type="checkbox"/> Other _____ | | | |

Is your condition getting worse?
☐ Yes ☐ No ☐ Constant ☐ Comes & goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable <small>even if only sometimes</small>	Painful
Lying on back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lovemaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.

- | | | |
|-----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Standing | <input type="checkbox"/> Driving | <input type="checkbox"/> Operating equipment |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Twisting | <input type="checkbox"/> Work with arms above head |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Crawling | <input type="checkbox"/> Typing |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Bending | <input type="checkbox"/> 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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