AUTO RELATED ACCIDENT

1 ABOUT YOU

Today's Date: ____/____/____ File #: _____

Name: _____

2 ABOUT THE ACCIDENT

Date of Accident: _____

Time of Accident: _____ ❑ AM ❑ PM

Were you the ❑ Driver ❑ Front Passenger ❑ Rear Passenger

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 the 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 the other vehicle? _____

Direction other vehicle was headed? ❑ N ❑ S ❑ E ❑ W

Speed of the other vehicle? _____

In your words, please describe the accident: _____

_____

_____

_____

_____

_____

_____

3 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 and 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	❑ Fatigue	❑ Shortness of breath
❑ Memory loss	❑ Tension	❑ Stomach upset
❑ Headache(s)	❑ Neck Pain	❑ Nausea
❑ Blurred vision	❑ Neck Stiff	❑ Back pain
❑ Buzzing in ear	❑ Jaw problems	❑ Lower back pain
❑ Ears ringing	❑ Arms/Shoulder pain	❑ Back stiffness
❑ Difficulty sleeping	❑ Numb Hands/Fingers	❑ Leg pain
❑ Irritability	❑ Chest pain	❑ 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	Painful
Lying on back	❑	❑	❑
Lying on side	❑	❑	❑
Lying on stomach	❑	❑	❑
Sitting	❑	❑	❑
Standing	❑	❑	❑
Stretching	❑	❑	❑
Lovemaking	❑	❑	❑
Walking	❑	❑	❑
Running	❑	❑	❑
Sports	❑	❑	❑
Working	❑	❑	❑
Lifting	❑	❑	❑
Bending	❑	❑	❑
Kneeling	❑	❑	❑
Pulling	❑	❑	❑
Reaching	❑	❑	❑

Please continue on back

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4 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

5 ADDITIONAL INSURANCE

2nd Insurance Source or Auto Insurance

Type of Insurance: _____

Co. Name: _____

Address: _____

Phone #: _____

Insured's Name: _____

Policy #: _____

Claim #: _____

Insured's SSN: _____

Date of Birth: _____ / _____ / _____

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: