WORK RELATED ACCIDENT

1 ABOUT YOU

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

Name: _____

2 ABOUT THE ACCIDENT

Date of Accident: _____

Time of Accident: _____ ❑ AM ❑ PM

Was your accident directly related to your work?

❑ Yes ❑ No

Briefly describe the events that occurred jus before and during your accident: _____

_____

_____

Give the address where accident occurred: (If other than employer's address) _____

_____

_____

Was anyone else present during the 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

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

WORK RELATED ACCIDENT

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

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: