PLEASE COMPLETE THE FOLLOWING FOR ANY INJURIES / ACCIDENTS

Accident/Injury date _____ Hour _____ ☐AM ☐PM Location _____

Accident/Injury caused by: ☐Auto Accident ☐On-the-Job Injury ☐Sports ☐Home Other_____

Describe the circumstances of the Accident/Injury _____

_____

_____

Did you report the injury to your Foreman or Employer? ☐Yes ☐No Person's Name_____

Did he/she recommend care and treatment at our office? ☐Yes ☐No

If **Auto Accident**, were you:☐Driver ☐Passenger =☐Front☐Rear seat; Wearing seat belt? ☐Yes ☐No; ☐Pedestrian

Were you struck from: ☐Behind ☐Right Side ☐Left Side ☐ Front; Auto was ☐Parked /☐Stopped at the time

Did your auto strike the other(s)? ☐Yes ☐No, Or, did the other auto strike yours? ☐Yes ☐No; ☐Undetermined

Were traffic citations issued to you? ☐ Yes ☐No To the driver of the other car? ☐ Yes ☐No To the driver of your car? ☐Yes ☐No Was the accident reported to the Police and was a Police Report made? ☐Yes☐No

List the extent of **your injuries** as you know them_____

_____

_____

Did you require any post-accident hospitalization? ☐Yes ☐No Location / How long?_____

Did you obtain any Emergency Care/Treatment? ☐Yes ☐No Location_____

Check **ANY** and **ALL** symptoms that you have noticed as a result of the accident/injury:

___Headache	___Pins & Needles in Arms	___Chest Pain	___Face Flushed	___Feet Cold
___Neck Pain	___Numbness in Fingers	___Shortness of Breath	___Buzzing in Ears	___Hands Cold
___Neck Stiffness	___Pins & Needles in Legs	___Fatigue	___Nausea	___ Stomach Upset
___Sleeping Problems	___Numbness in Legs/Toes	___Depression	___Fainting	___ Constipation
___Back Pain	___Irritability/Tension	___Lights Bother Eyes	___Loss of Smell	___ Cold Sweats
___Leg pain/Sciatica	___Dizziness/Loss of Balance	___Loss of Memory	___Loss of Taste	___Fever
___Shoulder/Arm Pain	___Head Seems Too Heavy	___Ringing in Ears	___Diarrhea	___Muscle Cramps

List any symptoms other than above_____

Were you having any problems **before** this Accident/Injury? ☐ Yes ☐No Describe _____

Have you lost any days of work?☐Yes ☐No Dates _____ Date returned to work _____

If working, are you on ☐Regular Duty ☐Light/Modified Duty - For how long? _____

Insurance Companies involved:

Your Company_____ Address _____

Other Person's _____ Address _____

Have you been contacted by an Insurance Adjuster or Company Representative regarding this claim? ☐ Yes ☐No Person's Name_____

Have you obtained an Attorney regarding this case? ☐ Yes ☐No Will you be obtaining an Attorney? ☐Yes ☐No

Attorney's Name _____ Phone # (_____)_____

Address _____ City/State/Zip _____

Patient's signature _____ **Date** _____

Parent, Guardian or Spouse's signature _____ **Date** _____