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AUTO / WORK RELATED ACCIDENT FORM

ABOUT YOU

Name: ____

Today's Date: ______/______/______ File# ________________

WORK RELATED ACCIDENT

Date & Time of Accident:______________________ AM / PM

Was your accident directly related to your work? YES / NO

Briefly describe the event 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 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:______________________ YES / NO

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

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 o which you were traveling?

____

In which direction were you headed? ____N ____S ____E ____W

What was the approx. speed of the vehicle? ______ MPH

Did the impact to the 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 other vehicle? _________________________

Direction other vehicle was headed? ____ N ____S ____E ____W

Approx. speed of other vehicle? ___________ MPH

In your words please describe the accident:____

____

____

Doctor's Notes:

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:

__Dizziness	__ Difficulty sleeping	__Back pain	__Nausea
__Fatigue	__Arms / Shoulder Pain	__Back stiffness	__Blurred vision
__Tension	__Numb Hands/Fingers	__Numb Feet /Toes	__Buzzing in ear
__Leg Pain	__Shortness of breath	__Jaw problem	__Irritability
__Headaches	__Stomach Upset	__Memory Loss	__Neck pain
__Chest pain	__Lower back pain	__Blurred vision	__Neck stiff

__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 stomach	☐	☐	☐
Lyng on side	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Lovemaking	☐	☐	☐
Walking	☐	☐	☐
Running	☐	☐	☐
Sports	☐	☐	☐
Working	☐	☐	☐
Lifting	☐	☐	☐
Bending	☐	☐	☐
Kneeing	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐

Have you retained an attorney: ___YES ___NO

If yes, whom:____

His / Her Phone #:______________________________________

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

Do you work with others your age who can help you with any heavy lifting?

While in recovery, is there any light duty work you could request? YES /NO

ADDITIONAL INSURANCE INFORMATION

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 charged, please inform our front desk personnel. Please remember you are ultimately responsible for your account.

________________________________ ___/___/____

Signature Date