

Accidental Injury Form

Name _____ Date _____

Date of Accident _____ Time of Accident ____ am/pm Location _____

How did the accident occur? _____ Auto Collision _____ On-The-Job-Injury _____ Other _____

Describe the circumstances of the accident: _____

____ Yes ____ No Did you report the injury to you foreman or employer?

____ Yes ____ No Did he/she recommend treatment at our office?

If auto accident, which were you? _____ Driver _____ Passenger _____ Pedestrian

If auto collision, where were you struck? _____ Behind _____ Front _____ Left side _____ Right side _____ Parked

____ Yes ____ No Did your car strike the other(s) involved?

____ Yes ____ No Did the other car strike your car?

____ Yes ____ No Did you receive a traffic citation as a result of the accident?

____ Yes ____ No Did the other driver?

____ Yes ____ No Did you go to the hospital as a result of the accident? Which hospital? _____

____ Yes ____ No Were x-rays taken?

List the extent of the injuries as you know them: _____

Check symptoms you have noticed since the accident

- | | | | | |
|------------------------|--------------------------|--------------------------|----------------------|--------------------|
| ____ Headache | ____ Irritability | ____ Numbness - Toes | ____ Face Flushed | ____ Feet Cold |
| ____ Neck Pain | ____ Chest Pain | ____ Shortness of Breath | ____ Buzzing in Ears | ____ Hands Cold |
| ____ Neck Stiff | ____ Dizziness | ____ Fatigue | ____ Loss Of Balance | ____ Stomach Upset |
| ____ Sleeping Problems | ____ Head Seems Heavy | ____ Depression | ____ Fainting | ____ Constipation |
| ____ Back Pain | ____ Pins & Needles-Arms | ____ Light Bothers Eyes | ____ Loss Of Smell | ____ Cold Sweats |
| ____ Nervousness | ____ Pins & Needles-Legs | ____ Loss of Memory | ____ Loss of Taste | ____ Fever |
| ____ Tension | ____ Numbness-Fingers | ____ Ears Ring | ____ Diarrhea | |

List any symptoms other than above _____

____ Yes ____ No Have you lost any days of work? Dates out: _____

Name of your insurance company: _____

Name of other insurance company: _____

____ Yes ____ No Have you been contacted by an insurance adjuster or company representative about this claim?

____ Yes ____ No Is an attorney advising you in this case?

Attorney Name _____ Phone _____

Address _____

(Please return form to receptionist)