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 insuance 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)