IF YOURS IS AN ACCIDENTAL INJURY PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of Accident_____Hour_____AM_____PM Location_____

How did Accident Occur? ☐ Auto Collision ☐ On the job Injury ☐ Other_____

If not an auto collision, please describe the circumstances: _____

_____

_____

Did you report the injury to your foreman or employer? ☐ YES ☐ NO

Did he/she (they) recommend care at our office ☐ YES ☐ NO

If auto accident, were you ☐ Driver ☐ Passenger ☐ Pedestrian

If auto collision, were you struck from ☐ Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Auto was Parked

Did your car strike the other(s) involved? ☐ YES ☐ NO ☐ Undetermined

OR did the other car strike yours? ☐ YES ☐ NO

As a result of the accident, 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

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

_____

_____

Did you require post accident hospitalization? ☐ YES ☐ NO

Check symptoms you have noticed since accident:

☐ Headache	☐ Dizziness	☐ Light Bothers Eyes	☐ Diarrhea
☐ Neck Pain	☐ Head Seems Too Heavy	☐ Loss of Memory	☐ Feet Cold
☐ Neck Stiffness	☐ Pins and Needles in Arms	☐ Ears Ring	☐ Hands Cold
☐ Problems Sleeping	☐ Pins and Needles in Legs	☐ Face Flushed	☐ Stomach Upset
☐ Back Pain	☐ Numbness in Fingers	☐ Buzzing in Ears	☐ Constipation
☐ Nervousness	☐ Numbness in Toes	☐ Loss of Balance	☐ Cold Sweats
☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever
☐ Irritability	☐ Fatigue	☐ Loss of Smell	☐ Chest Pain
☐ Depression	☐ Toss of Taste	☐ Other: _____	

Symptoms other that above:_____

Have you lost any days of work? ☐ YES ☐ NO Dates: _____

Insurance Companies involved:

My Company:_____

Company of person responsible for injuries: _____

Have you been contacted by an insurance adjuster of company representative regarding this claim? ☐ YES ☐ NO

Do you have an attorney that has advised you in this case? ☐ YES ☐ NO

Attorney's Name:_____ Phone number:_____

Address:_____

Personal Injury Verification

Date _____

Date of Injury _____ Date of 1st Treatment _____

Cause of Injury _____

_____

Patient _____ SS # _____

Address _____ D.O.B._____

City _____ State _____ Zip _____

Phone # _____ Work # _____

P.I.P. Information

Insurance Co. _____ Claim # _____

Address _____

City _____ State _____ Zip _____

Adjuster _____

Phone # _____Fax # _____

_____

Third Party Information

Insurance Co. _____ Claim # _____

Address _____

City _____ State _____ Zip _____

Adjuster _____

Phone # _____Fax # _____

_____

Attorney Information

Name _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Fax # _____

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