

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:

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

Symptoms other than 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: _____