

Auto or Work Related Accident

1. About You

NAME _____ TODAY'S DATE _____

2a. Auto Related Accident

1. Did the police come to the accident site? YES NO
2. Was a police report filed? YES NO
3. Was a traffic violation issued? YES NO If "yes", to whom? _____
4. Were there witnesses? YES NO
5. About your vehicle:
 - A. Did your vehicle have airbags? Yes No
 - If "yes", did they inflate? Yes No
6. If another vehicle was involved:
 - A. Direction traveling: _____
7. Please describe the accident: _____

2b. Work Related Accident

Date of Accident: _____ Time of Accident: _____ a.m. p.m.

Was accident directly work related? YES NO

1. Please describe the events immediately before and during the accident: _____

2. Location / Address of accident: _____
3. Were there witnesses? YES NO
4. Did you report the accident to your employer? YES NO
5. What recommendations did you employer make immediately after you reported accident? _____

6. Have you had this type of accident before? YES NO
7. To your knowledge, has this type of accident happened in your workplace before? YES NO
8. Is your job physically stressful? YES NO
9. Is your job mentally stressful? YES NO

3. After Injury

1. Describe how you felt right after the accident: _____
2. Have you seen any other doctor? YES NO If "yes", who & where: _____
3. Describe any treatment you have received: _____
4. Were x-rays taken? YES NO If "yes", what part of your body was x-rayed? _____
5. Was medication prescribed? YES NO
6. Have you worked since this injury? YES NO
7. Are your activities restricted? YES NO
8. Check the symptoms resulting from this accident:
 Dizziness Sleep Problems Low Back Pain Mid Back Pain Fatigue
 Tension Memory Loss Headache(s) Blurred Vision Leg Pain
 Nausea Arm/Shoulder Pain Ringing in Ears Chest Pain Numb toes/feet
 Neck Pain Irritability Upset Stomach Stiffness Other
9. Is your condition: Stable Improving Worsening Varies
10. Rate your comfort level performing these activities:

	Comfortable	Uncomfortable Painful	
Lying on back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Recovery

1. How many hours do you work a day? _____ Hours
2. Prior to your injury, were you able to do the same work as others your age? YES NO
3. Can you request light duty during recovery? YES NO

5. Additional Insurance – Auto Insurance or Workers Compensation

Type of Insurance: _____ Insurance Company Name: _____
Adjustors Name: _____ Adjustors Phone Number: _____
Claim Number: _____ Insured's Name: _____
Insured's DOB: _____ Insured's SSN: _____