

Auto / Work-Related Accident - Page 1 of 2

1. About You

NAME: _____ **PATIENT #:** _____ **Today's Date:** _____

2a. Auto Related Accident

Date of Accident: _____ **Time of Accident:** _____ a.m. p.m. **# of people in vehicle:** _____

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 who? _____
4. Were there witnesses? Yes No
5. Were you surprised by the impact? Yes No

6. About your vehicle:

01. Name of the location / street you were travelling on: _____
02. Make / Model / Year: _____
03. Direction were you heading: _____
04. Estimated speed: _____
05. Your vehicle was impacted in/at the: Front Rear Right Side Left Side Other
06. During impact, you were facing: Right Left Forward Backward
07. Were you wearing a seat belt? Yes No
08. Did your vehicle have airbags? Yes No
If "yes", did they inflate? Yes No
09. In relation to the base of your skull, where was the headrest?
 Above Below At base of skull
10. What did your vehicle impact? Another Vehicle Other: _____
11. Did any part of your body strike anything in the vehicle? Yes No
If "yes", please explain: _____

7. If another vehicle was involved:

01. Make / Model / Year: _____
02. Direction travelling: _____
03. Estimated speed: _____

8. Please describe the accident: _____

2b. Work Related Accident

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

Was accident directly related to work? Yes No

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

2. Location/Address of accident: _____
3. Were there witnesses? Yes No Who? _____
4. Did you report accident to your employer? Yes No
5. What recommendations did your 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 Ever happened in your workplace?
8. In general:
 01. Is your job physically stressful? Yes No
 02. Is your job mentally stressful? Yes No
 03. Is your workplace noisy? Yes No
9. Have you changed jobs in the past year? Yes No

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3. After Injury

1. Were you ever unconscious? Yes No
> If "yes", how long? _____
2. Describe how you felt immediately after the accident:

3. Have you seen any other doctor? Yes No
> If "yes", how long after the accident? _____
> How did you get there? _____
> Name of Hospital: _____
> Name & Type of Doctor: _____
4. Describe any treatment you have received: _____
5. Were x-rays taken? Yes No
6. Was medication prescribed? Yes No
7. Have you worked since this injury? Yes No
8. Are your work activities restricted? Yes No
9. Check the symptoms resulting from this accident:

<input type="checkbox"/> Dizziness	<input type="checkbox"/> Sleep issues	<input type="checkbox"/> Low back pain	<input type="checkbox"/> Back pain
<input type="checkbox"/> Memory loss	<input type="checkbox"/> Irritability	<input type="checkbox"/> Arm/Shoulder pain	<input type="checkbox"/> Nausea
<input type="checkbox"/> Headache(s)	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Numb hands/fingers	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Tension	<input type="checkbox"/> Upset stomach	<input type="checkbox"/> Leg pain
<input type="checkbox"/> Ringing ears	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Stiff neck
<input type="checkbox"/> Back stiffness	<input type="checkbox"/> Numb feet/toes	<input type="checkbox"/> Other	
10. Your condition is:

<input type="checkbox"/> Stable	<input type="checkbox"/> Improving	<input type="checkbox"/> Worsening	<input type="checkbox"/> Varies
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11. 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"/>
12. Have you retained an attorney? Yes No
If "yes": Name: _____
Phone#: _____

4. Recovery

- To evaluate the effect that continuing work will have on your recovery, please complete the following:**
1. How many hours do you work each day? _____
 2. Please indicate your daily job duties and any activities which you are occasionally asked to perform:

<input type="checkbox"/> Standing	<input type="checkbox"/> Driving	<input type="checkbox"/> Operating Equipment	
<input type="checkbox"/> Sitting	<input type="checkbox"/> Twisting	<input type="checkbox"/> Work With Arms Above Head	
<input type="checkbox"/> Walking	<input type="checkbox"/> Crawling	<input type="checkbox"/> Typing	
<input type="checkbox"/> Lifting	<input type="checkbox"/> Bending	<input type="checkbox"/> Stooping	<input type="checkbox"/> Other
 3. What positions can you work in with minimum physical effort and for how long? _____ N/A
 4. Prior to the injury, were you able to do the same work as other people your age? Yes No
 5. Can anyone help you with lifting? Yes No
 6. Can you request light duty in recovery? Yes No

5. Additional Insurance

2nd Insurance Source or Auto Insurance

Type of Insurance: _____

Insurance Company Name: _____

Address: _____

City: _____ ST: _____ Zip: _____

Phone: _____ Claim #: _____

Insured's Name: _____

Policy #: _____ Group #: _____

Insured's SS #: _____ D.O.B. ____/____/____

Insured's Employer: _____

Insurance Agent's Name: _____

If any of your medical or account information has changed, please let us know.

Please know that you are ultimately responsible for payment of your account.

Signature _____ Date _____

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