

# Accidental Injury Information

Date of Accident \_\_\_\_\_ Hour \_\_\_\_\_ am/pm Location \_\_\_\_\_

How did the accident occur? \_\_\_\_\_ Auto accident \_\_\_\_\_ On the job injury \_\_\_\_\_ Other \_\_\_\_\_

If not an auto accident, please describe the circumstances: \_\_\_\_\_

## Industrial Accident:

Did you report the injury to your foreman or employer? Y N Individual's Name \_\_\_\_\_

Did he (they) recommend care at our office? Y N Have you seen another doctor for your injury? Y N

## Auto Accident:

You were the: \_\_\_\_\_ Driver \_\_\_\_\_ Passenger \_\_\_\_\_ Front Seat \_\_\_\_\_ Back Seat \_\_\_\_\_ Pedestrian

Vehicle was struck from: \_\_\_\_\_ Behind \_\_\_\_\_ Right Side \_\_\_\_\_ Left Side \_\_\_\_\_ Front \_\_\_\_\_ Auto was Parked

Weather Conditions: \_\_\_\_\_ Using Seatbelts? Y N

Did your car strike the other(s) involved? Y N OR Did the other car strike yours? Y N

As a result of the accident were traffic citations issued to you? Y N To the driver of the other car? Y N

To the driver of the car you were a passenger of? Y N Please describe the accident: \_\_\_\_\_

List the extent of injuries as you know them: \_\_\_\_\_

Did you require post-accident hospitalization? Y N Where? \_\_\_\_\_

## Check any symptoms you have noticed since the accident:

_____ Back Pain	_____ Face Flushed	_____ Lights bother Eyes	_____ Numbness in Toes
_____ Buzzing in Ears	_____ Fainting	_____ Loss of Balance	_____ Pins & Needles in Arms
_____ Chest Pain	_____ Fatigue	_____ Loss of Memory	_____ Pins & Needles in Legs
_____ Cold Sweats	_____ Feet Cold	_____ Loss of Smell	_____ Shortness of Breath
_____ Constipation	_____ Fever	_____ Loss of Taste	_____ Sleeping Problems
_____ Depression	_____ Hands Cold	_____ Neck Pain	_____ Stomach Ache
_____ Diarrhea	_____ Head seems Heavy	_____ Neck Stiff	_____ Tension
_____ Dizziness	_____ Headaches	_____ Nervousness	_____ Other
_____ Ears Ringing	_____ Irritability	_____ Numbness in Fingers	Please Explain: _____

Did you have any symptoms prior to injury? Y N Which symptoms? \_\_\_\_\_

Have you previously injured the area of today's chief complaint? Y N

Have you been treated for any health condition by a physician in the last year? Y N

Have you lost any days of work? Y N Dates: \_\_\_\_\_

## Insurance Companies Involved:

My Company: \_\_\_\_\_

Company of Responsible Party: \_\_\_\_\_

Have you been contacted by and insurance adjuster or company representative regarding this claim? Y N

Have you hired an Attorney? Y N

## Other Doctors Seen for this Injury:

Dr. Name: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ X-rays? Y N

Urinalysis? Y N Blood Tests? Y N Prescribed Drugs? Y N What? \_\_\_\_\_

Shots? Y N Traction? Y N Physiotherapy? Y N Other: \_\_\_\_\_

Results: \_\_\_\_\_

Length of time under care of this Physician: \_\_\_\_\_ History of Prior Injury, Illness or Surgery: \_\_\_\_\_