ACCIDENTAL INJURY FORM

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 an auto collision, please describe the circumstances: _____
_____
_____

Did you report the injury to your foreman or employer? ☐ Yes ☐ No
Did he/she recommend care at our office? ☐ Yes ☐ No

If an auto accident, were you: ☐ Driver ☐ Passenger ☐ Pedestrian
If an 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
Or did the other car strike yours? ☐ Yes ☐ No ☐ Undetermined
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 injuries as you know them:_____
_____
_____
Did you require post-accident hospitalization? ☐ Yes ☐ No
Check symptoms you have noticed since the accident

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

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 or company representative regarding this claim? ☐ Yes ☐ No
Do you have an attorney that has advised you in this case? ☐ Yes ☐ No
Name _____ Telephone _____
Address _____