Accidental Injury Information

Name _____ Today's Date _____

Date of Accident _____ Time of Accident _____ AM PM

Location of Accident _____

Type of Accident: [ ] Auto/Traffic [ ] Work/On Job [ ] At Home [ ] Other _____

Describe how the accident happened in your own words: _____

_____

_____

_____

If auto accident, were you the [ ] Driver [ ] Passenger [ ] Pedestrian? Were you wearing a seat belt? [ ] Yes [ ] No

If passenger, were you sitting in the [ ] Front [ ] Right Rear [ ] Left Rear? [ ] Other? _____

Did your vehicle hit other vehicle(s)? [ ] Yes [ ] No Estimated speed of your vehicle at impact? _____ MPH

Was your vehicle hit by another vehicle(s)? [ ] Yes [ ] No Estimated speed of other vehicle at impact? _____ MPH

What kind of vehicle hit yours? _____ What kind of vehicle were you in? _____

Did you get medical attention for your injuries? [ ] Yes [ ] No Were you admitted to the hospital? [ ] Yes [ ] No

How long did you stay? _____

What treatment was rendered? _____

List any other doctors you have seen as a result of this accident: _____

_____

Have you lost any time from work because of this accident? [ ] Yes [ ] No If yes, give days of disability: _____

Totally disabled from _____ to _____ Partially disabled from _____ to _____

Have you returned to work since the accident? [ ] Yes [ ] No

VEHICLE YOU WERE IN:

Driver _____

Insured: _____

Address: _____

Phone: _____

Auto Insurance Co.: _____

Ins. Co. Address: _____

Adjuster: _____

Phone: _____

Policy #: _____

Claim # _____

OTHER VEHICLE

Driver: _____

Insured: _____

Address: _____

Phone: _____

Auto Insurance Co.: _____

Ins. Co. Address: _____

Adjuster: _____

Phone: _____

Policy #: _____

Claim # _____

CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

[ ] Headache
[ ] Neck pain
[ ] Neck stiffness
[ ] Sleeping problems
[ ] Back pain

[ ] Chest pain
[ ] Dizziness
[ ] Head seems too heavy
[ ] Pins & needles in Arms
[ ] Pins & needles in Legs
[ ] Numbness in fingers

[ ] Numbness in toes
[ ] Shortness of breath
[ ] Fatigue
[ ] Depression
[ ] Light bothers eyes
[ ] Loss of memory

[ ] Loss of balance
[ ] Fainting spells
[ ] Diarrhea
[ ] Ringing in ears
[ ] Nervousness
[ ] Irritability

[ ] Cold Hands/Feet
[ ] Stomach upset
[ ] Constipation
[ ] Cold sweats
[ ] Tension

Symptoms other than above: _____

Have you been contacted by an Insurance Adjuster or Company Representative regarding this claim? [ ] YES [ ] NO

Do you have an attorney who has advised you in this case? [ ] YES [ ] NO Name: _____

Address of Attorney: _____ Phone No: _____

Patient's Signature: _____ Date: _____