Auto-Related Accident

About You

Today's date______________________________

Name ______________________________

Accident Details

Date of accident ______________________________

Time of accident ______________________________

Were you the

☐ Driver ☐ Front Passenger ☐ Rear Passenger

If a traffic violation was issued, to who was it issued?

____

Number of people in the accident vehicle? __________

	Yes	No
Did the police come to the accident site?		
Was a report filed?		
Were there any witnesses?		
Were you wearing your seatbelt?		
Was this vehicle equipped with airbags?		
If yes, did it/they inflate?		

In relation to the base of your skull, where was the headrest?

☐Above ☐ Below ☐ At base of skull

What did your vehicle impact?

☐ Another vehicle ☐ Other

If other, explain ______________________________

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No

If yes, please describe ______________________________

____

Make and model of the vehicle you were occupying

____

Name of the location/street on which you were traveling

____

In which direction were you headed? N S E W

What was the approximate speed of your vehicle? _________

Did the impact to your vehicle come from the

☐ Front Rear ☐ Right Side ☐ Left Side ☐ Other

During impact, were you facing

☐ Right ☐ Left ☐ Forward

If accident vehicle made impact with another vehicle, make and model of that other vehicle ______________________________

____

Direction other vehicle was headed N S E W

Speed of other vehicle __________

In your words, please describe the accident ______________

____

____

After Injury

Did accident render you unconscious? ☐ Yes ☐ No

If yes, for how long? ______________________________

Please describe how you felt immediately after the accident

____

____

Have you gone to the hospital or seen any other doctor? ☐ Yes ☐ No

When did you go?

☐ Just after accident ☐ The next day ☐ 2 days plus

How did you get there?

☐ Ambulance ☐ Private transportation

Name of hospital and/or attending doctor ______________

____

Was he/she a ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S.

Describe any treatment you received ______________

____

	Yes	No
Were x-rays taken?		
Was medication prescribed?		
Have you been able to work since this injury?		
Are your work activities restricted as a result of this injury?		

Indicate the symptoms that are a result of this accident:

☐ Dizziness	☐ Difficulty Sleeping	☐ Jaw Problems	☐ Nausea
☐ Memory loss	☐ Irritability	☐ Arms/Shoulder pain	☐ Back pain
☐ Headache(s)	☐ Fatigue	☐ Numb hands/fingers	☐ Lower back pain
☐ Blurred vision	☐ Tension	☐ Chest pain	☐ Back stiffness
☐ Buzzing in ear	☐ Neck pain	☐ Shortness of breath	☐ Leg pain
☐ Ears ringing	☐ Neck stiff	☐ Stomach upset	☐ Numb feet/toes

☐ Other ______________________________

Is your condition getting worse? ☐ Yes ☐ No

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable (even if only sometimes)	Painful
Lying on back	☐	☐	☐
Lying on side	☐	☐	☐
Lying on stomach	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Lovemaking	☐	☐	☐
Walking	☐	☐	☐
Running	☐	☐	☐
Sports	☐	☐	☐
Working	☐	☐	☐
Lifting	☐	☐	☐
Bending	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐

Have you retained an attorney? ☐ Yes ☐ No

If yes, whom ______________________________

His/her phone ______________________________

Recovery

To evaluate the effect that continuing work will have on your recovery, please complete the following:

How many hours are in your normal work day? ____________

Please indicate your daily job duties and any activities which you are occasionally asked to perform.

☐ Standing ☐ Driving ☐ Operating equipment
☐ Sitting ☐ Twisting ☐ Work with arms above head
☐ Walking ☐ Crawling ☐ Typing
☐ Lifting ☐ Bending ☐ Stooping
☐ Other ____

In what positions can you work with minimum physical effort and for how long? ________________________________
____ ☐ N/A

Prior to the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No ☐ N/A

Do you work with others who can help you with any heavy lifting? ☐ Yes ☐ No ☐ N/A

While in recovery, is there any light duty work you could request? ☐ Yes ☐ No ☐ N/A

"The doctor of the future
will give no medicine,
but will interest his patients
in the care of the human frame."
-Thomas Edison

Additional Insurance

Second Insurance Source or Auto Insurance

Type of Insurance ________________________________

Company Name ________________________________

Address ________________________________

Phone ________________________________

Insured's Name ________________________________

Policy # ________________________________

Claim # ________________________________

Insured's SS # ________________________________

D.O.B. ________________________________

Insured's Employer ________________________________

Agent's Name ________________________________

If any of your medical or account information has changed, please inform our front desk personnel. Please remember you are ultimately responsible for your account.

____
Signature

____
Date