

ACCIDENTAL INJURY REPORT

If your visit to our office is due to an accident of any type, please review all events associated with the accident.

Date of Accident _____ Hour _____ AM/PM Location _____

How did the accident occur? Auto Collision On-the-Job Injury Other _____

Please Describe the Circumstances _____

Did you report the injury to supervision or personnel office? Yes No

Did they recommend care at our office? Yes No

If this was an auto accident, were you Driver Passenger Pedestrian

If this was an auto collision, were you struck from Behind Right Side Left Side 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

Name of Driver who hit you _____

List the extent of the injuries as you know them _____

Did you require hospitalization after the accident? Yes No Hospital _____

Please Check Symptoms You Have Noticed Since The Accident

- | | | |
|--|--|---|
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Excessive Perspiration | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Digestive Disorders |
| <input type="checkbox"/> Mid back (pain/stiffness) | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Equilibrium Disorders |
| <input type="checkbox"/> Low back (pain/stiffness) | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Head seems too heavy |
| <input type="checkbox"/> Swelling (where) _____ | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Difficulty in excessive |
| <input type="checkbox"/> Hands cold; feet cold | <input type="checkbox"/> Anxiety | <input type="checkbox"/> standing <input type="checkbox"/> walking |
| <input type="checkbox"/> Restriction of neck motion | <input type="checkbox"/> Fainting | <input type="checkbox"/> riding <input type="checkbox"/> bending |
| <input type="checkbox"/> Upper back pain and stiffness | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Neck pain/stiffness upon arising |
| <input type="checkbox"/> Eyes sensitive to light/loss of focus | <input type="checkbox"/> Constipation | <input type="checkbox"/> Pain radiating into <input type="checkbox"/> arm; <input type="checkbox"/> leg |
| <input type="checkbox"/> Head and shoulders feel tired, heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> right; <input type="checkbox"/> left; <input type="checkbox"/> both |
| <input type="checkbox"/> Pins and needles in arms/legs | <input type="checkbox"/> Eyestrain | <input type="checkbox"/> Difficulty in Lifting |
| <input type="checkbox"/> Numbness in (fingers/arms/legs) | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> light <input type="checkbox"/> moderate |
| <input type="checkbox"/> Difficulty in riding in car | <input type="checkbox"/> Face flushed | <input type="checkbox"/> heavy <input type="checkbox"/> after a few times |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Palpitation | <input type="checkbox"/> Pain radiating into |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Tremors | <input type="checkbox"/> Neck <input type="checkbox"/> Base of Skull |
| <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Shoulder <input type="checkbox"/> Arms |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Mental Dullness | |

Symptoms other than above _____

Have you lost any days work? NO YES FROM _____ TO _____

Your Insurance Company Name _____

Insurance Co. of Person Responsible for Injuries _____ Claim # _____

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? no yes

Attorney's Name _____ Address _____ Phone # _____

Patients Signature _____