ACCIDENTAL INJURY REPORT

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: _____
_____
_____
_____
Immediately following the accident, how did you feel? _____
How did you feel the next day? _____
Were you unconscious? ___Yes ___No In a daze? ___Yes ___No Did you go to the hospital? ___Yes ___No
If you went to the hospital, when? At time of accident ___Yes ___No Next day ___Yes ___No Other _____
How did you get to hospital? Ambulance ___Yes ___No Private transportation ___Yes ___No
Did the ambulance attendants place you in: Neck Collar ___Yes ___No Splints ___Yes ___No Brace ___Yes ___No
Name of hospital: _____ Attended by Dr. _____
Were you x-rayed at hospital? ___Yes ___No If so, what was the diagnosis?_____
_____ Were you admitted to the hospital? ___Yes ___No
How long did you stay?_____ What treatment was rendered? _____
What recommendations were made?_____
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 dates of disability:
Totally disabled from _____to_____ Partially disabled from _____to_____
Have you returned to work since the accident? No____ Yes____ If yes, date you returned to work: _____
If yes, are you currently on: Light duty work_____ Regular duty work_____ Full Time_____ Part Time____

Since this accident occurred, are your symptoms: Improving _____ Getting Worse _____ Same _____

Do you notice any activity restrictions as a result of this injury? Yes___ No___ Please describe: _____
_____
_____

Have you been contacted by an insurance adjustor or company representative about this accident? __Yes __No
If so, name, phone # of person contacting you: _____
Have you retained an attorney? Yes ___ No___ Date attorney retained or to be retained: _____
Attorney's name: _____ Phone_____
Address: _____
City:_____ State:_____ Zip:_____

Were there any witnesses? Yes_____ No_____ Name (s) _____

Other pertinent information: _____
_____
_____
_____

_____ _____
Patient's Signature Date

Please complete the questions on the next page in the category of accident you had.

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AUTO / TRAFFIC ACCIDENT

Was the accident reported to Police Department? ___Yes ___No Number of people in your car _____
Were traffic citations issued to? ____You ____Driver of your car ____Driver of other car ____None
Were you a _____Driver _____Passenger _____ Pedestrian?
What kind of vehicle were you in? _____Truck _____Car _____Motorcycle _____Other
If passenger, were you sitting in _____Front _____Right Rear _____Left Rear
Did your vehicle hit other vehicle(s)? _____Yes _____No Estimated speed of your vehicle at impact _____mph
Was your vehicle hit by other vehicle(s)? _____Yes _____No Estimated speed of other vehicle at impact _____mph
What kind of vehicle hit yours? _____Truck _____Car _____Motorcycle _____Other
Was the impact from _____Front? _____From the right side? _____From the left side? _____From the rear?
Were you wearing seat belts? ____Yes ____No Did you strike anything in the vehicle at the time of impact? Yes / No
If yes, specify: ___ Steering Wheel ___Dashboard ___Windshield ___ Side Door/Window ___Arm rests ___Air Bag
Please state part of body: ___Chest ___Chin ___Knee ___Shoulder ___Hand ___Head _____Other

Name of Driver of Your vehicle _____
Name of Driver of Other vehicle _____

Have you been contacted by a representative of the insurance company? _____Yes _____No

WORK/ON JOB ACCIDENT

List any equipment, machinery and/or object related to the accident: _____
Was accident reported to you supervisor or employer? ___Yes ___No If so. To whom? _____
Has a worker's Compensation claim been filed? ___Yes ___No Insurance Carrier_____
Name and office phone # of your immediate supervisor/ foreman: _____
Type of work being done at time of injury: _____
Length of time you have worked there prior to accident: _____ Have you been injured before? ___Yes ___No
Job Title / Activity: _____

In a typical 8-hour workday, I (Circle # of hours/activity)

Sit: 1 2 3 4 5 6 7 8 hours; Stand: 1 2 3 4 5 6 7 8 hours; Walk 1 2 3 4 5 6 7 8 hours;

On the job I perform:	Not at all	Occasionally	Frequently	Continuously
Bend/stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Reach above head	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Push/Pull	( )	( )	( )	( )
I lift up to:				
10 lbs	( )	( )	( )	( )
25 lbs	( )	( )	( )	( )
50 lbs	( )	( )	( )	( )
Over 50 lbs	( )	( )	( )	( )

Patient's Signature: _____ Date:_____