Accidental Injury Report

If your visit to this clinic 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 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 HE (THEY) RECOMMEND CARE AT OUR OFFICE? ☐ YES ☐ NO

IF AUTO ACCIDENT, WERE YOU ☐ DRIVER ☐ PASSENGER ☐ PEDESTRIAN

IF 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

NAME OF DRIVER WHO HIT YOU: _____

LIST THE EXTENT OF THE INJURIES AS YOU KNOW THEM _____

_____

_____

DID YOU REQUIRE HOSPITALIZATION AFTER THE ACCIDENT? ☐ NO ☐ YES _____ Name of Hospital

Check Symptoms You Have Noticed Since Accident

- ☐ SHORTNESS OF BREATH
- ☐ EXCESSIVE PERSPIRATION
- ☐ MID BACK (PAIN; STIFFNESS)
- ☐ LOW BACK (PAIN; STIFFNESS)
- ☐ SWELLING (WHERE) _____
- ☐ FEET COLD; HANDS COLD
- ☐ RESTRICTION OF NECK MOTION
- ☐ UPPER BACK PAIN AND STIFFNESS
- ☐ BUZZING AND/OR RINGING IN EARS
- ☐ EYES SENSITIVE TO LIGHT, LOSS OF FOCUS
- ☐ HEAD AND SHOULDERS FEEL TIRED; HEAVY
- ☐ PINS AND NEEDLES IN (ARMS; LEGS)
- ☐ NUMBNESS IN (FINGERS; ARMS; LEGS)
- ☐ DIFFICULTY IN RIDING IN CAR
- ☐ HEADACHE
- ☐ NECK PAIN
- ☐ NECK STIFFNESS
- ☐ INSOMNIA
- ☐ TENSION
- ☐ IRRITABILITY
- ☐ LOSS OF TASTE
- ☐ LOSS OF SMELL
- ☐ LOSS OF MEMORY
- ☐ DIARRHEA
- ☐ NEURITIS
- ☐ ANXIETY
- ☐ FAINTING
- ☐ CHEST PAIN
- ☐ DIZZINESS
- ☐ CONSTIPATION
- ☐ DEPRESSION
- ☐ EYESTRAIN
- ☐ NAUSEA, VOMITING
- ☐ FACE FLUSHED
- ☐ PALPITATION
- ☐ TREMORS
- ☐ SINUS TROUBLE
- ☐ MENTAL DULLNESS
- ☐ EXTREME NERVOUSNESS
- ☐ EXTREME FATIGUE
- ☐ PAIN BEHIND EYES
- ☐ DOUBLE VISION
- ☐ DIGESTIVE DISORDERS
- ☐ EQUILIBRIUM PROBLEMS
- ☐ HEAD SEEMS TOO HEAVY
- ☐ DIFFICULTY IN EXCESSIVE
  - ☐ STANDING ☐ WALKING
  - ☐ RIDING ☐ BENDING
- ☐ NECK (PAIN; STIFFNESS) UPON ARISING
- ☐ LOW BACK (PAIN; STIFFNESS) UPON ARISING
- ☐ PAIN RADIATING INTO ☐ ARM; ☐ LEG
  - ☐ RIGHT; ☐ LEFT; ☐ BOTH
- ☐ DIFFICULTY IN LIFTING
  - ☐ LIGHT ☐ MODERATE
  - ☐ HEAVY ☐ AFTER A FEW TIMES

PAIN RADIATING INTO:

- ☐ NECK
- ☐ BASE OF SKULL
- ☐ SHOULDER
- ☐ ARMS
- ☐ HIPS
- ☐ LEGS

SYMPTOMS OTHER THAN ABOVE _____

HAVE YOU LOST ANY DAYS WORK? DATES: FROM _____ TO _____

Insurance Companies Involved:

YOUR INSURANCE COMPANY NAME _____

INSURANCE COMPANY 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? ☐ YES ☐ NO

ATTORNEY'S NAME _____ ADDRESS _____ TELEPHONE _____

PATIENT'S SIGNATURE _____

If Yours Is An Accidental Injury, Please Complete The Information On The Reverse Side Also.