IF YOURS IS AN ACCIDENTAL INJURY PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of the Accident _____ Time _____ AM / PM Location _____

How did Accident Occur? ☐ Auto Collision ☐ On the job Injury ☐ Other _____

If On-the-job Injury, how did it happen? _____

_____

_____

Did you report the injury to you foreman or employer? ☐ Yes ☐ No Your Job Title/Duties? _____

Did you tell them you were coming to 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 ☐ Parked ☐ Other _____

Did your car strike the other(s) involved? ☐ Yes ☐ No ☐ Undetermined

OR did the other car strike yours? ☐ Yes ☐ No ☐ Undetermined

As a result of the accident, were traffic citations issued to you? ☐ Yes ☐ No

Or to the driver of the other car? ☐ Yes ☐ No

Or to the driver of your car? ☐ Yes ☐ No ☐ Not Applicable

List the extent of the injuries as you know them _____

_____

_____

Did you require post-accident hospitalization? ☐ Yes ☐ No

Check Symptoms you have noticed since the accident:

☐ Headache	☐ Dizziness	☐ Light Bothers Eyes	☐ Diarrhea
☐ Neck Pain	☐ Head Seems Too Heavy	☐ Loss of Memory	☐ Feet Cold
☐ Neck Stiffness	☐ Pins & Needles in Arms	☐ Ears Ring	☐ Hands Cold
☐ Problems Sleeping	☐ Pins & Needles in Legs	☐ Face Flushed	☐ Stomach Upset
☐ Back Pain	☐ Numbness in Fingers	☐ Buzzing in Ears	☐ Constipation
☐ Nervousness	☐ Numbness in Toes	☐ Loss of Balance	☐ Cold Sweats
☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever
☐ Irritability	☐ Fatigue	☐ Loss of Smell	☐ _____
☐ Chest Pain	☐ Depression	☐ Loss of Taste	☐ _____

Symptoms other than above _____

_____

Have you lost any days of work? ☐ Yes ☐ No Dates: _____

Insurance Companies Involved (Auto Accidents Only)

My Company _____

Company of person responsible for injuries _____

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 _____ Phone _____