

# ACCIDENTAL INJURY FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of accident: \_\_\_\_\_ AM PM

Location of Accident: \_\_\_\_\_

## AUTO INJURY:

Were you: Driver Passenger Pedestrian

Were you struck from: Behind Right Side Left Side Front

Did your car strike another vehicle or object? Yes No Don't Know

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

## WORK INJURY:

How did the injury occur? \_\_\_\_\_

Did you report the injury to a supervisor? Yes No

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Name of person to contact regarding your claim: \_\_\_\_\_

### **CHECK THE SYMPTOMS THAT YOU HAVE NOTICED SINCE THE ACCIDENT:**

- |                                       |   |   |  |
|---------------------------------------|---|---|--|
| <input type="checkbox"/> Headache     | <input type="checkbox"/> Sleeping Problems      | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Diarrhea      |
| <input type="checkbox"/> Neck Pain    | <input type="checkbox"/> Head Feels Heavy       | <input type="checkbox"/> Loss of Memory     | <input type="checkbox"/> Feet Cold     |
| <input type="checkbox"/> Neck Stiff   | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Ears Ringing       | <input type="checkbox"/> Hands Cold    |
| <input type="checkbox"/> Dizziness    | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Face Flushed       | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain    | <input type="checkbox"/> Numbness in Fingers    | <input type="checkbox"/> Buzzing in Ears    | <input type="checkbox"/> Constipation  |
| <input type="checkbox"/> Nervousness  | <input type="checkbox"/> Numbness in Toes       | <input type="checkbox"/> Loss of Balance    | <input type="checkbox"/> Cold Sweats   |
| <input type="checkbox"/> Tension      | <input type="checkbox"/> Shortness of Breath    | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Fever         |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Loss of Smell      | <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> Chest Pain   | <input type="checkbox"/> Depression             | <input type="checkbox"/> Loss of Taste      | _____                                  |

Did you require post-accident hospitalization? Yes No

Have you lost any days at work? Yes No If yes, \_\_\_\_\_ through \_\_\_\_\_

## INSURANCE COMPANY:

Your insurance company: \_\_\_\_\_ Address: \_\_\_\_\_

Other party's name: \_\_\_\_\_ Address: \_\_\_\_\_

Other party's insurance co.: \_\_\_\_\_ Address: \_\_\_\_\_

Have you been contacted by an insurance adjuster regarding this claim? Yes No

If yes, name of adjuster: \_\_\_\_\_ Company: \_\_\_\_\_

Do you have an attorney that has advised you in this case? Yes No

If yes, attorney's name: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date