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:

❑Headache	❑Sleeping Problems	❑Light Bothers Eyes	❑Diarrhea
❑Neck Pain	❑Head Feels Heavy	❑Loss of Memory	❑Feet Cold
❑Neck Stiff	❑Pins & Needles in Arms	❑Ears Ringing	❑Hands Cold
❑Dizziness	❑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	❑Other: _____
❑Chest Pain	❑Depression	❑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