ACCIDENTAL INJURY REPORT

If your clinic visit is due to an accident, please describe all events associated with it.

DATE OF ACCIDENT ______________________ HOUR OF ACCIDENT ______________ AM PM

TYPE OF ACCIDENT: ☐ WORK RELATED ☐ TRAFFIC ☐ OTHER

WORK RELATED ACCIDENT

EMPLOYER ______________________ TYPE OF BUSINESS ______________

WAS ANY EQUIPMENT, MACHINERY AND/OR OBJECT RELATED TO ACCIDENT? WHAT KIND? ______________

WAS ACCIDENT REPORTED TO SUPERVISOR AND/OR EMPLOYER? ☐ YES ☐ NO

HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? ☐ YES ☐ NO

TRAFFIC ACCIDENT

WHAT KIND OF VEHICLE WAS INVOLVED IN ACCIDENT? ☐ TRUCK ☐ CAR ☐ MOTORCYCLE ☐ OTHER

WERE YOU A ☐ DRIVER ☐ PASSENGER ☐ PEDESTRIAN?

IF A PASSENGER, PLEASE INDICATE YOUR LOCATION IN THE CAR ______________

WAS YOUR VEHICLE MOVING WHEN THE ACCIDENT OCCURRED? ☐ YES ☐ NO MPH? ______________

DID YOUR VEHICLE HIT OTHER VEHICLE/S? ☐ YES ☐ NO WHERE? ______________

DID OTHER VEHICLE/S HIT YOUR VEHICLE? ☐ YES ☐ NO WHERE? ______________

WAS ACCIDENT REPORTED TO POLICE DEPARTMENT? ☐ YES ☐ NO

WERE TRAFFIC CITATIONS ISSUED? ☐ YES ☐ NO TO WHOM? ______________

DESCRIBE ACCIDENT INCLUDING CAUSE/S AND SURROUNDING CIRCUMSTANCES ______________

____

____

PRESENT COMPLAINT

☐ HEADACHE
☐ HEAD SEEMS TOO HEAVY
☐ HEAD & SHOULDERS TIRED & HEAVY
☐ MENTAL DULLNESS
☐ LOSS OF MEMORY
☐ EQUILIBRIUM PROBLEMS
☐ DIZZINESS
☐ FAINTING
☐ TREMORS
☐ PALPITATION
☐ NECK PAIN
☐ NECK STIFFNESS
☐ NECK MOTION RESTRICTED
☐ UPPER BACK PAIN/STIFFNESS
☐ MID BACK PAIN/STIFFNESS
☐ LOW BACK PAIN/STIFFNESS

☐ PINS & NEEDLES IN ARMS/LEGS
☐ NUMBNESS IN FINGERS, ARMS, LEGS
☐ CHEST PAIN
☐ SHORTNESS OF BREATH
☐ EYE STRAIN
☐ PAIN BEHIND EYES
☐ EYES SENSITIVE TO LIGHT
☐ EYES LOSS OF FOCUS
☐ DOUBLE VISION
☐ EARS BUZZING/RINGING
☐ LOSS OF TASTE
☐ LOSS OF SMELL
☐ SINUS TROUBLE
☐ EXTREME NERVOUSNESS
☐ TENSION
☐ IRRITABILITY

☐ ANXIETY
☐ EXTREME FATIGUE
☐ INSOMNIA
☐ NEURITIS
☐ FACE FLUSHED
☐ FACE PALE
☐ EXCESS PERSPIRATION
☐ DIGESTIVE DISORDERS
☐ NAUSEA, VOMITING
☐ DIARRHEA
☐ CONSTIPATION
☐ DEPRESSION
☐ SWOLLEN ________
☐ FEET/HANDS COLD
☐ DIFFICULTY IN PROLONGED CAR RIDING

☐ DIFFICULTY IN EXCESSIVE ☐ STANDING ☐ WALKING ☐ RIDING ☐ BENDING
☐ NECK, LOW BACK PAIN & STIFFNESS UPON RISING.
☐ PAIN RADIATING INTO ☐ RIGHT ARM ☐ RIGHT LEG ☐ BOTH ☐ LEFT LEG ☐ LEFT ARM ☐ BOTH
☐ DIFFICULTY IN EXCESSIVE LIFTING. ☐ LIGHT ☐ MODERATE ☐ HEAVY ☐ REPETITIVE
☐ PAIN RADIATING INTO ☐ NECK ☐ BASE OF SKULL ☐ SHOULDER ☐ ARMS ☐ HIPS ☐ LEGS

DID YOU REQUIRE POST-ACCIDENT HOSPITALIZATION? ☐ YES ☐ NO IF SO, WHERE? ______________

HAVE YOU HAD SIMILAR ACCIDENTS OR INJURIES BEFORE? ☐ YES ☐ NO

SYMPTOMS OTHER THAN ABOVE ______________

____

INSURANCE COMPANIES INVOLVED

INSURANCE COMPANY OF PARTY RESPONSIBLE FOR PAYMENT ______________ CLAIM # ________

HAVE YOU BEEN CONTACTED BY AN INSURANCE ADJUSTER OR COMPANY REPRESENTATIVE ABOUT CLAIM? ________

HAS YOUR ATTORNEY ADVISED YOU IN THIS CASE? ☐ YES ☐ NO

ATTORNEY'S NAME, ADDRESS & TELEPHONE # ______________

PATIENT'S SIGNATURE ______________ DATE ________