Accidental Injury Report

Name: _____ Today's Date:_____

Date of Accident: _____ Time of Accident: _____ AM PM

Location of Accident: _____

Type of Accident: _____ Auto/ Traffic _____ Work/On Job _____ At Home Other_____

In your own words Describe how the accident happened

_____

_____

_____

Immediately following the accident, how did you feel? _____

How did you feel the next day? _____

Were you unconscious? □ Yes □ No In a Daze? □ Yes □No Did you go to the hospital? □ Yes □No

If you went to the hospital, when? _____ At the time of accident _____Next Day Other_____

How did you get to the hospital? _____ Ambulance _____ Private Transportation Other_____

Did the ambulance attendants place you in: Neck collar? □ Yes □ No Splints? □ Yes □ No Brace? □Yes □No

Name of hospital: _____ Attended by Dr. _____

Were you x-rayed at the hospital? □ Yes □ No If so, what was the diagnosis? _____

How long did you stay? _____ What treatments were rendered? _____

What recommendations were made? _____

List any other doctors you have seen as a result of this accident: _____

_____

Have you lost any time from work because of the accident? □ Yes □ No If yes, give dates of disability: (go to next line)

Totally disabled from _____ to _____ Partially Disabled from _____ to _____

Have you returned to work since the accident? □ Yes □ No

Please complete the following:

Date	Employer	Occupation	Light Duty/Reg Duty	Full time/ Part time

Since the accident occurred, are you symptoms: Improving _____ Getting Worse _____ Same _____

Did you notice any activity restrictions as a result of the injury? □ Yes □ No Please describe: (go to next line)

_____

_____

Have you been contacted by an insurance adjuster or company representative about this accident? □ Yes □ No

If so, Name, Phone # of person contacting you: _____

Have you retained an attorney? □ Yes □ No Date attorney retained or will be: _____

Attorney's Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Were there any witnesses? □ Yes □ No Names(s): _____

Other pertinent information:

_____

_____

Patient's Signature: _____ Date:_____

Please complete the questions on the next page in the category of accident you had.

Signature:_____ Date:_____

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AUTO/TRAFFIC ACCIDENT

Was the accident reported to Police Department?
Were traffic citations issued to? _____ You _____Driver of the car _____ Driver of the car _____ None
Were you a _____ Driver _____ Passenger _____ Pedestrian
What kind of vehicle were you in? _____ Car _____ Truck _____ Motorcycle _____ Other
If passenger, were sitting in _____ Front _____ Rear Left _____Rear Back
Did you vehicle hit the other vehicle(s)? ☐ Yes ☐ No Estimated speed of your vehicle at impact? _____ MPH
Was your vehicle hit by other vehicle(s)? ☐ Yes ☐ No Estimated speed of your vehicle at impact? _____ MPH
What kind of vehicle hit yours? _____ Car _____ Truck _____ Motorcycle _____ Other
Was the impact from ____ the front? ____ the right side? ____ the left side? ____ the rear?
Were you wearing your seat belt? ☐ Yes ☐ No Did you strike anything in vehicle at time of the accident? ☐ Yes ☐ No
If yes, specify: ____ Steering wheel ____ Dashboard ____ Windshield ____ Side door ____ Arm rest ____ Side window
Please state part of body: ____ Chest ____ Chin ____ Knee ____ Shoulder ____ Hand ____ Head _____ Other

VEHICLE YOU WERE IN:	OTHER VEHICLE:
Driver	Driver
Insured	Insured
Address	Address
Phone	Phone
Auto Insurance Co.	Auto Insurance Co.
Ins. Co. Address	Ins. Co. Address
Adjustor	Adjustor
Phone	Phone
Policy #	Policy #
Claim #	Claim #

Have you been contacted by a representative of the insurance company? ☐ Yes ☐ No
Date Contacted: _____ By: _____ Insurance Company _____
Your agent's name: _____ Phone # _____
Have you contacted your insurance company? ☐ Yes ☐ No

WORK/ON JOB ACCIDENT

List any equipment, machinery and/or object related to the accident: _____
Was the accident reported to a supervisor or employer? ☐ Yes ☐ No If so, whom? _____
Has a Worker's Compensation claim been filed? ☐ Yes ☐ No Insurance carrier: _____
Name of your immediate supervisor/foreman: _____ Office Phone #: _____
Type of work being done at time of injury: _____
Length of time you have worked there prior to injury: _____ Have you been injured before? ☐ Yes ☐ No
Job title/ Activity: _____
In a typical 8-hour day workday, I (circle # of hours/activity)
Sit: 1 2 3 4 5 6 7 8 hours Stand: 1 2 3 4 5 6 7 8 hours Walk: 1 2 3 4 5 6 7 8 hours

ON THE JOB I PERFOM:	Not at all	Occasionally	Frequently	Continuously
Bend/Stop	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Reach above head	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Push/Pull	☐	☐	☐	☐
I LIFT UP TO:				
10lbs.	☐	☐	☐	☐
25lbs.	☐	☐	☐	☐
50lbs.	☐	☐	☐	☐

Signature:_____ Date:_____