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

TRAFFIC ACCIDENT
WHAT KIND OF VEHICLE WAS INVOLVED IN ACCIDENT? ☐ TRUCK ☐ CAR ☐ MOTORCYCLE ☐ OTHER
WERE YOU A ☐ DRIVER ☐ PASSENGER ☐ PEDESTRIAN? WERE YOU WEARING A SEAT BELT? YES ,NO
IF A PASSENGER PLEASE INDICATE YOUR LOCATION IN THE CAR ____
WAS YOUR VEHICLE MOVING WHEN THE ACCIDENT OCCURED? ☐ YES ☐ NO WHERE? ________________________
DID YOUR VEHICLE HIT OTHER VEHICLE? ☐ YES ☐ NO WHERE? ____
DID OTHER VEHICLE/S HIT YOUR VEHICLE? ☐ YES ☐ NO WHERE? ____
WAS ACCIDENT REPORTED TO THE 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 AND 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 AND 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

SYMPTONS OTHER THAN ABOVE ____
DID YOU REQUIRE POST-ACCIDENT HOSPITALIZATION? ☐ YES ☐ NO IF SO, WHERE? ___________________________
HAVE YOU HAD SIMILAR ACCIDENTS OR INJURIES BEFORE? ☐ YES ☐ NO IF SO WHEN?________________________

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 _________________