

# 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 \_\_\_\_\_  
Describe how the accident happened in your own words: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 time of accident?  Yes  No Next Day  Yes  No Other \_\_\_\_\_  
How did you get to the hospital? Ambulance  Yes  No Private transportation  Yes  No  
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 hospital?  Yes  No If so, what was the diagnosis? \_\_\_\_\_  
\_\_\_\_\_ Were you admitted to the hospital?  Yes  No  
How long did you stay? \_\_\_\_\_ What treatment was 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 this 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 this accident occurred, are your symptoms: Improving \_\_\_\_\_ Getting Worse \_\_\_\_\_ Same \_\_\_\_\_  
Do you notice any activity restrictions as a result of this injury?  Yes  No Please describe: \_\_\_\_\_  
\_\_\_\_\_

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 to be retained: \_\_\_\_\_  
Attorney's name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Were there any witnesses?  Yes  No Name(s): \_\_\_\_\_  
Other pertinent information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

OVER

# ACCIDENTAL INJURY REPORT

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

## AUTO/TRAFFIC ACCIDENT

Was the accident reported to Police Department?  Yes  No      Number of people in your car? \_\_\_\_\_

Were traffic citations issued to? \_\_\_\_\_ You \_\_\_\_\_ Driver of your car \_\_\_\_\_ Driver of other car \_\_\_\_\_ None

Were you a \_\_\_\_\_ Driver \_\_\_\_\_ Passenger \_\_\_\_\_ Pedestrian?

What kind of vehicle were you in? \_\_\_\_\_ Car \_\_\_\_\_ Truck \_\_\_\_\_ Motorcycle \_\_\_\_\_ Other

If passenger, were you sitting in \_\_\_\_\_ Front \_\_\_\_\_ Right Rear \_\_\_\_\_ Left Rear

Did your vehicle hit 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 other vehicle at impact? \_\_\_\_\_ MPH

What kind of vehicle hit your's? \_\_\_\_\_ Car \_\_\_\_\_ Truck \_\_\_\_\_ Motorcycle \_\_\_\_\_ Other

Was the impact from \_\_\_\_\_ front? \_\_\_\_\_ From the right side? \_\_\_\_\_ From the left side? \_\_\_\_\_ From the rear?

Were you wearing seat belts?  Yes  No      Did you strike anything in vehicle at time of impact?  Yes  No

If yes, specify: \_\_\_\_\_ Steering wheel \_\_\_\_\_ Dashboard \_\_\_\_\_ Windshield \_\_\_\_\_ Side door \_\_\_\_\_ Arm rests \_\_\_\_\_ Side Window

Please state part of body; \_\_\_\_\_ Chest \_\_\_\_\_ Chin \_\_\_\_\_ Knee \_\_\_\_\_ Shoulder \_\_\_\_\_ Hand \_\_\_\_\_ Head \_\_\_\_\_ Other

### VEHICLE YOU WERE IN:

Driver
Insured
Address
Phone
Auto Insurance Co.
Ins. Co. Address
Adjustor
Phone
Policy #
Claim #

### OTHER VEHICLE:

Driver
Insured
Address
Phone
Auto Insurance Co.
Ins. Co. Address
Adjustor
Phone
Policy #
Claim #

Have you been contacted by a representative of the Insurance Company?  Yes  No

Date Contacted \_\_\_\_\_ By: \_\_\_\_\_ Insurance Company \_\_\_\_\_

Your Insurance 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 accident reported to supervisor or employer?  Yes  No      If so, to whom? \_\_\_\_\_

Has a Worker's Compensation claim been filed?  Yes  No      Insurance Carrier \_\_\_\_\_

Name of your immediate supervisor/foreman: \_\_\_\_\_ Office Phone Number \_\_\_\_\_

Type of work being done at time of injury: \_\_\_\_\_

Length of time you have worked there prior to accident: \_\_\_\_\_ Have you been injured before?  Yes  No

### Job Title/Activity:

In a typical 8-hour 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 perform:	Not at all	Occasionally	Frequently	Continuously
Bend/Stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Reach above head	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Push/Pull	( )	( )	( )	( )
I LIFT UP TO:	( )	( )	( )	( )
10lbs.	( )	( )	( )	( )
25 lbs	( )	( )	( )	( )
50 lbs.	( )	( )	( )	( )

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

Date \_\_\_\_\_