IF YOURS IS AN ACCIDENTAL INJURY PLEASE

COMPLETE THE FOLLOWING QUESTIONS

Date of Accident:_____Hour _____AM_____PM Location _____

How Did Accident Occur? ____Auto Collision _____On-The-Job _____Other _____

If an Auto Collision, Please Describe The Circumstances _____

_____

_____

Did You Report the Injury to your Foreman or Employer? _____ Yes _____ No

Did He (They) Recommend Care at Our Office? ____ Yes ____ No

If Auto Accident, Were you ____Driver ____ Passenger ____ Pedestrian

If Auto Collision Were you Struck From ____Behind ___Right Side ___Front ___Auto Was Parked

Did Your Car Strike The Other(s) Involved? ___Yes ___No

Did The Other Car Strike Yours? ___Yes ___No ___ Undetermined

As a Result of the Accident, Were Traffic Citations Issued to You? ___ Yes ___ No

To the Driver of The Other Car ___Yes ___ No To The Drive of Your Car ___Yes ___ No

List the Extent of the Injuries as You Know Them _____

_____

_____

Did you Require Post-Accident Hospitalization ? ___ Yes ___NO

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT

__Headache	__Irritability	__Numbness in Toes	__Face Flushed
__Neck Pain	__Chest Pain	__Shortness of Breath	__Buzzing in Ears
__Neck Stiff	__Dizziness	__Fatigue	__Loss of Balance
__Sleeping Problems	__Head seems to heavy	__Depression	__Loss of Smell
__Back Pain	__Pins & Needles in Arms	__Lights Bother Eyes	__Fainting
__Nervousness	__Pins & Needles in Legs	__Loss of Memory	__Loss of Taste
__Tension	__Numbness in Fingers	__Ears Ring	__Diarrhea
__Feet Cold	__Hands Cold	__Stomach Upset	__Constipation
__Fever	__Other		

Symptoms other than above _____

_____

Have you Lost Any Days off Work? ___Yes___No If Yes What Dates _____

Insurance Companies Involved:

My Company _____

Company of Person Responsible for Injuries _____

Have you been contacted by an Insurance Adjuster or Company representative regarding this claim? __ Yes __ No

Do you have an Attorney that has advised you in this case: ___Yes ___No

Attorney's

Name _____Address _____Telephone _____