

Accidental Injury Questions

Patient's Name _____

Injury was Auto/Vehicle Injury On-the Job Other _____

Date of Accident _____ Hour _____ AM PM (Circle One) Location _____

Auto/Vehicle Injury Questions

Where were you in the vehicle? Driver Passenger Pedestrian

Where were you struck? Behind Right side Left side Front

Did your vehicle cause the accident? Yes No Did another vehicle cause the accident? Yes No

Were you expecting the impact? Yes No

Did you strike any part of your body on your vehicle? Yes No Not sure

If yes, what? _____

Was your head turned at the time of impact? Yes No. If yes, which way? Right Left

Did you require post-accident hospitalization? Yes No

Were you wearing a seatbelt? Yes No Shoulder harness? Yes No

Did you lose consciousness after the impact? Yes No. If yes, for how long? _____

Did you experience a flash of light or explosion in your head? Yes No

Circle any additional symptoms you have had since the accident

Nausea Light headed Sleeplessness Loss of memory Irritability Depression Loss of taste Loss of smell

Difficulty concentrating Face feels flushed Chest pain Head seems too heavy Shortness of breath

Other _____

Work/Other Injury Questions

If not an auto injury, please describe your injury _____

Did you report your injury to your foreman or employer? Yes No. If yes, who? _____

Did they recommend care in this office? Yes No

Disability Information

Have you lost any days of work? Yes No. Dates _____

Insurance Information

My insurance company _____ Claim# _____

Have you reported the accident to your insurance company? Yes No. Adjuster's name _____

Responsible party's insurance company _____

Have you been contacted by an insurance adjuster or representative regarding your claim or injury? Yes No

Do you have an attorney who has advised you in this case? Yes No

Attorney's Name _____

Address _____

Phone _____