IF YOURS IS AN AUTO OR WORK ACCIDENT PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of accident_____Location of accident_____

How did accident occur_____

Please describe The Accident and Injury_____

If work related: Did you report the injury(s) to supervisor or employer?_____

Name and phone number of supervisor or authorized person _____

If auto accident: Were you ( ) Driver ( ) Passenger ( ) Pedestrian

Were you hit: ( ) From behind ( ) In front ( ) Left side ( ) Right side ( ) While parked

Did your car strike the other(s) involved? ( ) Yes ( ) No

Did the other car strike yours? ( ) Yes ( ) No ( ) Undetermined

Were traffic citations issued to you as a result of an auto accident? ( ) Yes ( ) No

Were traffic citations issued to another driver as a result of an auto accident? ( ) Yes ( ) No

Were traffic citations issued to the driver of your care as a result of an auto accident? ( ) Yes ( ) No

List the extent of your injuries as you know them: _____

_____

Did you require hospitalization after the accident? ( ) Yes ( ) No

CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT

( ) HEADACHES	( ) DIZZINESS	( ) PINS/NEEDLES IN ARM(S)	( ) UPSET STOMACH
( ) NECK PAIN	( ) DEPRESSION	( ) PINS/NEEDLES IN LEG(S)	( ) FAINTING
( ) NECK STIFFNESS	( ) LOSS OF SMELL	( ) NUMBNESS IN FINGERS	( ) COLD SWEATS
( ) CONSTIPATION	( ) LOSS OF TASTE	( ) SHORTNESS OF BREATH	( ) FEEL COLD
( ) BACK PAIN	( ) EAR(S) RINGING	( ) LIGHT SENSITIVITY	( ) MEMORY LOSS
( ) NERVOUSNESS	( ) NUMBNESS AT TOES	( ) BUZZING IN EARS	( ) FEVER
( ) TENSION	( ) FATIGUE	( ) HANDS COLD	( ) DIARRHEA
( ) IRRITABILITY	( ) HEAD FEELS HEAVY	( ) LOSS OF BALANCE	( ) _____
( ) CHEST PAIN	( ) FACE FLUSHED	( ) SLEEPING PROBLEMS	( ) _____

Symptoms other than those mentioned above: _____

Have you ever had a similar accident(s) or injuries before? ( ) Yes ( ) No If yes, when? _____

Have you lost any days of work because of injuries? ( ) Yes ( ) No If yes, what dates? _____

INSURANCE COMPANIES INVOLVED

Name of your insurance company: _____

Name of insurance company responsible for your injuries: _____

Have you been contacted by an insurance adjuster or company rep regarding this accident? ( ) Yes ( ) No

Do you have an attorney that has advised you in this case? ( ) Yes ( ) No

Attorney Name: _____Phone:_____