

INJURY FORM – Please answer each question

TODAY'S DATE: _____

Name: _____ Birth date: _____ Social Security #: _____
Address: _____ City: _____ Zip: _____
Employer's Name: _____
Employer's Address: _____
Insurance company: _____ Ins. Co. Phone #: _____
Address: _____ Policy #: _____ Claim #: _____

NATURE OF ACCIDENT

Date of Accident: _____ Time of Day: _____

Were you: Driver Passenger Front Seat Back Seat

Number of people in your vehicle: _____

What direction were you headed? North South East West

On (name of street): _____

What direction was the other vehicle headed? North South East West

On (name of street): _____

Were you struck from: Behind Front Left Side Right Side

Were you knocked unconscious? No Yes If yes, for how long? _____

Were the police notified? Yes No

NATURE OF INJURY

Address where injury occurred _____

In your own words, please describe injury:

Were there any witnesses? Yes No Have you retained an attorney? Yes No

Did you have any physical complaints **BEFORE the injury**? Yes No

If yes, describe in detail: _____

Please Describe How You Felt:

During the injury: _____

Immediately after the injury: _____

Later that day: _____

The next day: _____

What are your present complaints and symptoms? _____

Where were you taken after the injury? _____

Have you been treated by another doctor since the injury? Yes No

If yes, please list the doctor's name and address: _____

What type of treatment did you receive? _____

Since this injury occurred, are your symptoms: Improving Getting worse Same

Have you lost time from work as a result of this injury? Yes No

If yes, please complete this question: Last Day Worked: _____

Type of Employment: _____

Are you being compensated for time lost from work? Yes No

If yes, what type of compensation: _____

Do you notice any activity restrictions as a result of this injury? Yes No

If yes, please describe in detail: _____

Do you have any congenital (from birth) factors which relate to this problem? Yes No

If yes, please describe: _____

Have you ever been involved in an accident before? Yes No

If yes, please describe, including date(s) and type(s) of accidents, as well as injury (ies) received:

Patient's Signature

Date