IF YOURS IS AN **ACCIDENTAL INJURY** PLEASE COMPLETE THE FOLLOWING:

Date of Accident____________________Time________________Location____

How did Accident Occur ( ) Auto ( ) On-the-job ( ) Other____
____

Did you report the injury to your foreman, employer or insurance company ( ) Yes ( ) No

Did your employer send you here ( ) Yes ( ) No Was your company doctor seen ( ) Yes ( ) No

If auto accident, were you ( ) Driver ( ) Passenger ( ) Pedestrian

If auto collision were you struck from ( ) Behind ( ) Driver's side ( ) Passenger Side
( ) Front ( ) Auto was parked

Did your car strike the other(s) Involved ( ) Yes ( ) No

or 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 driver of your car ( ) Yes ( ) No

List the extent of the injuries as you know them____
____

Did you require post-accident hospitalizations ( ) Yes ( ) No From__________________To______________________

Did symptoms start immediately ( ) Yes ( ) No If not when____

Check all symptoms you have noticed since accident:

( ) Headache	( ) Dizziness	( ) Light bother eyes	( ) Diarrhea
( ) Neck Pain	( ) Head seems too heavy	( ) Loss of Memory	( ) Feet Cold
( ) Sleeping Problems	( ) Pins & needles in Arms	( ) Ears Ring	( ) Hands Cold
( ) Back pain	( ) Numbness in Fingers	( ) Buzzing in Ears	( ) Constipation
( ) Nervousness	( ) Numbness in Toes	( ) Loss of Balance	( ) Cold Sweats
( ) Tension	( ) Shortness of Breath	( ) Fainting	( ) Fever
( ) Irritability	( ) Fatigue	( ) Loss of Smell	( )______________________
( ) Chest Pain	( ) Depression	( ) Loss of Taste	( )______________________

Did you have any complaints prior to the accident other than the above ( ) Yes ( ) No

Were any previous problems made worse ( ) Yes ( ) No ____

Have you lost any days of work ( ) Yes ( ) No Dates:____
Can you perform your normal work or house duties ( ) Yes ( ) No ____

Insurace 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

Name____________________________Address______________________________Phone__________________________