Auto/Work Related Accident

The Spine Center AT HILLS AND DALES
a division of SYNAPTIC

About You…

Name_____ File # _____ Today's Date_____

Auto Related Accident

Date and Time of Accident: _____ am pm
Were you the: Driver Front Passenger Rear Passenger
If a traffic violation was issued, to whom was it issued? _____
Number of people in the accident vehicle? _____
Did the police come to the accident site? yes no
Was a police report filed? yes no
Were there any witnesses? yes no
Were you wearing your seat belt? yes no
Was this vehicle equipped with airbags? yes no
If yes, did they inflate? yes no
In relation to the base of your skull, where was the headrest? Above Below At base of skull
What did your vehicle impact? Another Vehicle Other
If other, explain: _____
Did any part of your body strike anything in the vehicle? yes no
If yes, please describe: _____
Make and model of the vehicle you were occupying? _____
Name of the location/street on which you were traveling? _____
In which direction were you headed? N S E W
What was the approximate speed of your vehicle? _____
Did the impact of your vehicle come from the: Front Rear Right Side Left Side Other
During impact were you facing: Right Left Forward
Were you: Aware of or Surprised by the impact?
If accident vehicle made impact with another vehicle…
Make and model of the other vehicle_____
Speed of the other vehicle_____
Direction the other vehicle was headed: N S E W
In your words, please describe the accident. _____
_____

Work Related Accident

Date and Time of Accident: _____ am pm
Was your accident directly related to your work? yes no
Briefly describe the events that occurred just before and during your accident. _____
_____
Give the address where accident occurred: (if other than employer's address) _____
_____
Was anyone else present during your accident? yes no
Did you report your accident to your employer? yes no
What recommendations did your employer make just after your accident? _____
_____

Work Related Accident cont'd…

Has this type of accident happened to you before? yes no

To the best of your knowledge, has this accident occurred in your workplace before? yes no

In general:

Is your job physically stressful?	yes	no
Is your job mentally stressful?	yes	no
Is your workplace noisy?	yes	no
Have you changed jobs in the last year?	yes	no

After Injury

Did the accident render you unconscious? yes no

If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

_____

Have you gone to a hospital or seen any other doctors? yes no

When did you go? Just after accident The next day 2 days plus

How did you get there? Ambulance or Private transportation

Name of Hospital and/or Attending doctor: _____

Was he/she a: D.C. M.D. D.O. D.D.S.

Describe any treatment you received: _____

Were X-Rays taken?	yes	no
Was medicine prescribed?	yes	no
Have you been able to work since this injury?	yes	no
Are your work activities restricted as a result of this injury?	yes	no

Indicate the symptoms that are a result of this accident:

Dizziness	Difficulty sleeping	Jaw problems	Nausea
Irritability	Memory loss	Arms/shoulder pain	Back pain
Headache(s)	Fatigue	Numb hands/fingers	Lower back pain
Tension	Blurred vision	Chest pain	Back stiffness
Neck pain	Buzzing in ear	Shortness of breath	Leg pain
Ears ringing	Neck stiff	Stomach upset	Numb feet/toes

Other _____

Is your condition getting worse? yes no constant comes and goes

Indicate your level of comfort while doing the following activities:

	Comfortable	Uncomfortable (Even if only sometimes)	Painful
Lying on back			
Lying on side			
Lying on stomach			
Sitting			
Standing			
Stretching			
Lovemaking			
Walking			
Running			
Sports			
Working			
Lifting			
Bending			
Kneeling			
Pulling			
Reaching			

Have you retained an attorney? yes no

If yes, whom: _____
His/Her phone number: _____

Recovery

To evaluate the effect that continuing work will have on your recovery please complete the following:
How many hours are in your normal workday? _____

Please indicate your daily job duties and any activities which you are occasionally asked to perform:

Standing	Driving	Operating equipment	Lifting
Sitting	Twisting	Work with arms above head	Bending
Walking	Crawling	Typing	Stooping
Other _____			

What positions can you work in with minimum physical effort and for how long?

_____

Prior to the injury were you capable of working on an equal basis with others your age?	yes	no	N/A
Do you work with others who can help you with any heavy lifting?	yes	no	N/A
While in recovery, is there any light duty work you could request?	yes	no	N/A

Primary Auto Insurance

Type of Insurance: _____
Co. Name: _____
Address: _____
Phone #: _____
Insured's Name: _____
Policy #: _____ Claim #: _____

Additional Insurance

2nd Insurance Source or Auto Insurance

Type of Insurance: _____
Co. Name: _____
Address: _____
Phone #: _____
Insured's Name: _____
Policy #: _____ Claim #: _____
Insured's SS#: _____ D.O.B. _____
Insured's Employer: _____
Agent's Name: _____

If any of your medical or account information has changed, please inform our front desk personnel.

Please remember you are ultimately personally responsible for your account and acknowledge this by signing below.

X_____
Signature Date