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AFTER INJURY

Did 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 Doctor? 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 medication 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:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Memory loss | <input type="checkbox"/> Irritability | <input type="checkbox"/> Arms/Shoulder pain | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Headache(s) | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numb Hands/Fingers | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Tension | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Back stiffness |
| <input type="checkbox"/> Buzzing in ear | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Leg pain |
| <input type="checkbox"/> Ears ringing | <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Stomach upset | <input type="checkbox"/> Numb Feet/Toes |
| <input type="checkbox"/> Other | | | |

Is your condition getting worse?

Yes No Constant Comes & goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable <small>even if only sometimes</small>	Painful
Lying on back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lovemaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you retained an attorney: Yes No

If yes, whom: _____

His/Her Phone #: _____

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RECOVERY

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal work day? _____

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

- | | | |
|-----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Standing | <input type="checkbox"/> Driving | <input type="checkbox"/> Operating equipment |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Twisting | <input type="checkbox"/> Work with arms above head |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Crawling | <input type="checkbox"/> Typing |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Bending | <input type="checkbox"/> Stooping |

Other _____

What positions can you work in with minimum physical

effort and for how long? _____ N/A

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

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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 responsible for your account.

_____/_____/_____
SIGNATURE DATE

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