

ACCIDENTAL INJURY WORKSHEET
PLEASE COMPLETE THE FOLLOWING QUESTIONS

Name: _____

Date of Accident: _____ Time _____ Location _____

How did accident occur? Auto Collision Other

If not auto collision, please describe the circumstances _____

If auto accident, were you Driver Passenger PedestrianIf auto collision, were you struck from Behind Right Side Left side
 Front Auto was parkedDid your car strike the other (s) involved? Yes NoDid the other care strike yours? Yes NoAs a result of the accident was a traffic citation issued to you? Yes NoWere traffic citations issued to driver of other car? Yes NoWere traffic citations issued to driver of your car? Yes No

List the extent of the injuries as you know them _____

Have you seen a Doctor for this injury before coming to this office? Yes NoDid you receive treatment? Yes No If so describe _____Did you require post-accident hospitalization? Yes No

Check symptoms you have noticed since accident:

<input type="checkbox"/> Headache	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Loss of memory
<input type="checkbox"/> Neck pain	<input type="checkbox"/> Head seems to heavy	<input type="checkbox"/> Ears ring
<input type="checkbox"/> Neck stiffness	<input type="checkbox"/> Pins & needles in arms	<input type="checkbox"/> Face flushed
<input type="checkbox"/> Sleeping problems	<input type="checkbox"/> Pins & needles in legs	<input type="checkbox"/> Buzzing in ears
<input type="checkbox"/> Back pain	<input type="checkbox"/> Numbness in fingers	<input type="checkbox"/> Loss of balance
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Numbness in toes	<input type="checkbox"/> Fainting
<input type="checkbox"/> Tension	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Loss of smell
<input type="checkbox"/> Irritability	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Loss of taste
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Depression	<input type="checkbox"/> Hands cold
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Feet cold	<input type="checkbox"/> Cold sweats
<input type="checkbox"/> Stomach upset	<input type="checkbox"/> Constipation	<input type="checkbox"/> Other, specify _____
<input type="checkbox"/> Fever	<input type="checkbox"/> Light bothers eyes	<input type="checkbox"/> Shoulder Pain

Have you lost any days of work Yes No if yes, dates _____

Signed: _____

Date _____