Auto/Work Related Accident

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

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.

X_____
Signature Date

VIRGINIA HILL CHIROPRACTIC, PC

DR. KRIS PETERSON • DR. ADAM EISAMAN

DOCTOR'S LIEN

Patient's Name: _____

Accident Date: _____

I hereby authorize and direct the third party payor to pay directly to Virginia Hill Chiropractic such sums as may be due and owing for professional services rendered to me both by reason of the aforesaid accident and by reason of any other bills that are due and owing Virginia Hill Chiropractic and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect Virginia Hill Chiropractic, PC.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of pending payment. And I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

Patient's Signature: _____ Date: _____

Patient's Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

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