WORK RELATED ACCIDENT INFORMATION

LAST:_____**FIRST:**_____**DATE:**_____

Employer:_____

Employer Phone:_____Employer Fax:_____

Employer Address:_____

Your Occupation:_____

Last Date Worked:_____Are you off work? ____Yes ____No

Claim#:_____ DATE OF ACCIDENT:_____

Insurance Company:_____

Claim Adjuster:_____Phone:_____

Have you contacted an Attorney? ____Yes ____No

Attornyey's Name:_____Phone:_____

Address:_____

Has the injury been reported to your employer? ____Yes ____No

Immediately after the accident, did you feel dazed? ____Yes ____No

Did you lose consciousness? ____Yes ____No

Immediately after the accident, did you experience? ____Headache ____Neck Pain ____Low Back Pain

Did you see another doctor before coming here? ____Yes ____No

Did you go to a hospital after the accident: ____Yes ____No If yes, which hospital?_____

How did you get to the hospital? ____Ambulance _____Drove Self _____Police _____Somebody else

LAST:_____FIRST:_____DATE:_____

Were any of the following tests performed at the hospital?			____Yes	____No
	____XRAYS	____MRI	____CT SCAN	____LAB WORK
Have you lost time from work?			____Yes	____No
Can you perform physical work activities?			____Yes	____No
If no, because of:		____Pain	____Weakness	____Stress
Can you go to sleep without problems?			____Yes	____No
Do you awaken because of pain?			____Yes	____No
Did you have sleep problems before?			____Yes	____No

Is there anything else your feel that the doctor should be aware of with your condition?

_____

_____

_____

SIGNATURE:_____DATE:_____