# ACCIDENTAL INJURY FORM

NAME_____ DATE_____

Date of Accident_____ Time: ___am ___pm Location of Accident_____

## AUTO INJURY

Were You: ( ) Driver ( ) Passenger ( ) Pedestrian

Were you struck from: ( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked

Did your car strike the others involved: ( ) Yes ( ) No ( ) Undetermined

Did the other car strike yours: ( ) Yes ( ) No ( ) Undetermined

As a result of the Accident, were traffic citations issued to you? ( ) Yes ( ) No

## ON-THE-JOB INJURY

How did the injury occur?_____

Did you report the injury to your foreman or employer: ( ) Yes ( ) No

Employer:_____ Address:_____

## OTHER

Describe the circumstances of the accident (Be Specific):_____

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## CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

( ) Headache
( ) Neck Pain
( ) Stiff Neck
( ) Dizziness
( ) Back Pain
( ) Nervousness
( ) Tension
( ) Irritability
( ) Chest Pain
( ) Sleeping Problems
( ) Head Too Heavy
( ) Pins & Needles in Arms
( ) Pins & Needles in Legs
( ) Numbness in Fingers
( ) Numbness in Toes
( ) Shortness of Breath
( ) Fatigue
( ) Lights Bother Eyes
( ) Loss of Memory
( ) Ears Ringing
( ) Face Flushed
( ) Buzzing in Ears
( ) Loss of Balance
( ) Fainting
( ) Loss of Smell
( ) Loss of Taste
( ) Diarrhea
( ) Feet Cold
( ) Hands Cold
( ) Stomach Upset
( ) Constipation
( ) Cold Sweats
( ) Fever
( ) Other

Did you require post-accident hospitalization? ( ) Yes ( ) No
Have you lost any days of work? ( ) Yes ( ) No If Yes, _____ through _____

## INSURANCE INFORMATION

Your Insurance Company _____Address_____

Other Party's Name_____Address_____

Other Party's Ins. Co._____Address_____

Have you been contacted by an insurance adjuster regarding this claim: ( ) Yes ( ) No

If yes, name of adjuster_____Company_____

Do you have an attorney that has advised you in this case: ( ) Yes ( ) No

If yes, attorney's name_____Address_____

Signature_____