

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 () 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) _____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

- () Headache
- () Neck Pain
- () Neck Stiff
- () 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 in Breath
- () Fatigue
- () Depression
- () 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 adjustor regarding this claim? () Yes () No
If yes, name of adjustor _____ Company _____

Do you have an attorney that has advised you in this case: () Yes () No
If yes, attorney's name _____ Address _____

Signature _____ Date _____