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ACCIDENT INJURY FORM

Name_____ Date_____

Date of Accident_____Time_____am_____pm

Auto Accident

Were you: ( ) Driver ( ) Passenger ( ) Pedestrian

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

Did you car strike the other(s) 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 ( ) N0

Work Injury (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 Had Since The Accident

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

Did you require post-accident hospitalization: ( ) Yes ( ) No

Have you lost any days of work: ( ) Yes ( ) No

If Yes, _____through_____

Signature_____Date_____