

AUTO ACCIDENT OR PERSONAL INJURY

Please complete the following information regarding when & where the accident occurred:

Date: _____ Time: _____ a.m. p.m.

Location - Intersection/Street: _____

City: _____ State: _____

Were you the: Driver Front passenger Rear Passenger

Your Vehicle: Make _____ Model _____

Your approximate speed before the collision: _____ mph

Traffic violation issued: Yes No To whom: _____

Did police arrive at the accident site? Yes No

Was a police report filed? Yes No

What did you impact? Vehicle Other If Other, please explain:

Did any part of your body strike anything in the vehicle? Yes No

If Yes, please describe: _____

The impact to your vehicle came from which direction:

Front Rear Right Side Left Side Other

During impact, were you facing: Right Left Forward

At time of impact, were you: Aware Unaware

If you made impact with another vehicle, provide the following:

Other Vehicle: Make _____ Model _____

Other vehicle approximate speed: _____ mph

In your own words, please describe the accident: _____

WORK RELATED ACCIDENT

Please complete the following information regarding when & where the accident occurred:

Date: _____ Time: _____ a.m. p.m.

Location - Complete address: _____

City: _____ State: _____

Was your accident directly related to your work? Yes No

Briefly describe the events that occurred just **before and during** your accident: _____

Did you report your accident to your employer? Yes No

What recommendations did your employer make right after the accident? _____

Has this type of accident happened to you before?

Yes No Unsure

INSURANCE/CLAIM FILING INFORMATION

Insurance Name (PIP): _____

Agent/Adjuster's Name: _____

Telephone #: _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insurer's Name: _____

Policy #: _____ Claim #: _____

Third Party's Name: _____

Third Party's Insurance Name: _____

Agent/Adjuster Name: _____

Agent/Adjuster Telephone #: _____ - _____ - _____

AUTO ACCIDENT/WORK/PERSONAL INJURY INFORMATION

Did the accident render you unconscious? Yes No

If yes, for how long? _____

Please describe how you felt immediately after the accident:

Did you go to the hospital, or have you seen a doctor? Yes No

When did you go? Just after accident The next day 2 days plus

How did you get there? Ambulance Private Transportation

What hospital? _____

What doctor? _____

Describe any treatment you received:

X-Rays: None taken Please list the areas of the body that were x-rayed:

Any medications prescribed? Yes No Please list medications:

Have you been able to work since this injury? Yes No

Are your work activities restricted as a result of this injury? Yes No

Please indicate the symptoms that are a result of your accident:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Arms/Shoulder Pain | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Neck Stiffness |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Numb Feet/Toes |
| <input type="checkbox"/> Back Stiffness | <input type="checkbox"/> Ears Ringing | <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Numb Hands/Fingers |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Headache(s) | <input type="checkbox"/> Nausea | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Other: _____ | | | |

Is your condition getting worse? Yes No Constant Comes & Goes

Have you retained an attorney? Yes No

Attorney Name: _____

Telephone #: _____ - _____ - _____

Indicate your degree of comfort when performing these activities:

	COMFORTABLE	UNCOMFORTABLE	PAINFUL
Bending	_____	_____	_____
Kneeling	_____	_____	_____
Lifting	_____	_____	_____
Lovemaking	_____	_____	_____
Lying on Back	_____	_____	_____
Lying on Side	_____	_____	_____
Lying on stomach	_____	_____	_____
Pulling	_____	_____	_____
Reaching	_____	_____	_____
Running	_____	_____	_____
Sitting	_____	_____	_____
Sports	_____	_____	_____
Standing	_____	_____	_____
Stretching	_____	_____	_____
Walking	_____	_____	_____
Working	_____	_____	_____

How many hours are in your normal work day? _____ hrs.

Please indicate your daily job duties & any activities you occasionally perform:

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Bending | <input type="checkbox"/> Operating equipment | <input type="checkbox"/> Twisting |
| <input type="checkbox"/> Crawling | <input type="checkbox"/> Sitting | <input type="checkbox"/> Typing |
| <input type="checkbox"/> Driving | <input type="checkbox"/> Standing | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Stooping | <input type="checkbox"/> Work w/arms above head |
| <input type="checkbox"/> Other _____ | | |

Prior to injury, were you capable of working on an equal basis w/ your peers? Yes No

What positions can you work in w/minimum physical effort?

For how long? _____ N/A

Do you work w/others who can assist w/ any heavy lifting? Yes No

While in recovery, could you request any light duty? Yes No

Please inform us if any of your health or account information has changed. PLEASE UNDERSTAND THAT ANY BALANCE ON THIS ACCOUNT IS ULTIMATELY YOUR RESPONSIBILITY. Any outstanding balance unpaid by the insurance and/or attorney is due immediately upon settlement.

Signature: _____

Date: _____

Patient's Name: _____

QACC Witness: _____