ACCIDENTAL INJURY REPORT

Name_____ Today's Date_____

Date of Accident _____ Time of Accident _____ AM PM

Location of Accident _____

Type of Accident: _____ Auto/Traffic _____ Work/On Job _____ At Home Other _____

Describe how the accident happened in your own words: _____

Immediately following the accident, how did you feel? _____

How did you feel the next day? _____

Were you unconscious? ☐ Yes ☐ No In a daze? ☐ Yes ☐ No Did you go to the hospital? ☐ Yes ☐ No

If you went to the hospital, when? At time of accident? ☐ Yes ☐ No Next Day ☐ Yes ☐ No Other_____

How did you get to the hospital? Ambulance ☐ Yes ☐ No Private transportation ☐ Yes ☐ No

Did the ambulance attendants place you in: Neck collar ☐ Yes ☐ No Splints ☐ Yes ☐ No Brace ☐ Yes ☐ No

Name of Hospital:_____ Attended by Dr. _____

Were you x-rayed at hospital? ☐ Yes ☐ No If so, what was the diagnosis?_____

_____ Were you admitted to the hospital? ☐ Yes ☐ No

How long did you stay?_____ What treatment was rendered?_____

What recommendations were made?_____

List any other doctors you have seen as a result of this accident: _____

Have you lost any time from work because of this accident? ☐ Yes ☐ No If yes, give dates of disability:(go to next line)

Totally disabled from _____ to _____ Partially disabled from _____ to _____

Have you returned to work since the accident? ☐ Yes ☐ No Please complete the following:

Date	Employer	Occupation	Light duty/Reg .duty	Full time/Part-time

Since this accident occurred, are your symptoms: Improving_____ Getting Worse_____ Same_____

Do you notice any activity restrictions as a result of this injury? ☐ Yes ☐ No Please describe: _____

Have you been contacted by an insurance adjuster or company representative about this accident? ☐ Yes ☐ No

If so, name, phone # of person contacting you:_____

Have you retained an attorney? ☐ Yes ☐ No Date attorney retained or to be retained:_____

Attorney's name:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip: _____

Were there any witnesses? ☐ Yes ☐ No Name(s):_____

Other pertinent information:_____

Patient's Signature _____ Date _____

Please complete the questions on the next page in the category of accident you had.

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AUTO/TRAFFIC ACCIDENT

Was the accident reported to Police Department? ☐ Yes ☐ No Number of people in your car? _____

Were traffic citations issued to? _____ You _____ Driver of your car _____ Driver of other car _____ None

Were you a _____ Driver _____ Passenger _____ Pedestrian?

What kind of vehicle were you in? _____ Car _____ Truck _____ Motorcycle _____ Other

If passenger, were you sitting in _____ Front _____ Right Rear _____ Left Rear

Did your vehicle hit other vehicle(s)? ☐ Yes ☐ No Estimated speed of your vehicle at impact? _____ MPH

Was your vehicle hit by other vehicle(s)? ☐ Yes ☐ No Estimated speed of other vehicle at impact? _____ MPH

What kind of vehicle hit your's? _____ Car _____ Truck _____ Motorcycle _____ Other

Was the impact from _____ front? _____ From the right side? _____ From the left side? _____ From the rear?

Were you wearing seat belts? ☐ Yes ☐ No Did you strike anything in vehicle at time of impact? ☐ Yes ☐ No

If yes, specify: ——— Steering wheel _____ Dashboard _____ Windshield _____ Side door _____ Arm rests _____ Side Window

Please state part of body; _____ Chest _____ Chin _____ Knee _____ Shoulder _____ Hand _____ Head _____ Other

VEHICLE YOU WERE IN:	OTHER VEHICLE:
Driver	Driver
Insured	Insured
Address	Address
Phone	Phone
Auto Insurance Co.	Auto Insurance Co.
Ins. Co. Address	Ins. Co. Address
Adjustor	Adjustor
Phone	Phone
Policy #	Policy #
Claim #	Claim #

Have you been contacted by a representative of the Insurance Company? ☐ Yes ☐ No

Date Contacted _____ By: _____ Insurance Company _____

Your Insurance Agent's Name: _____ Phone # _____

Have you contacted your insurance company? ☐ Yes ☐ No

WORK/ON JOB ACCIDENT

List any equipment, machinery and/or object related to the accident? _____

Was accident reported to supervisor or employer? ☐ Yes ☐ No If so, to whom? _____

Has a Worker's Compensation claim been filed? ☐ Yes ☐ No Insurance Carrier _____

Name of <u>your</u> immediate supervisor/foreman: _____ Office Phone Number _____

Type of work being done at time of injury: _____

Length of time you have worked there prior to accident:: _____ Have you been injured before? ☐ Yes ☐ No

Job Title/Activity: _____

In a typical 8-hour workday, I (Circle # of hours/activity)

Sit:: 1 2 3 4 5 6 7 8 hours; Stand: 1 2 3 4 5 6 7 8 hours Walk: 1 2 3 4 5 6 7 8 hours

On the job I perform:	Not at all	Occasionally	Frequently	Continuously
Bend/Stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Reach above head	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Push/Pull				
I LIFT UP TO:	( )	( )	( )	( )
10lbs.	( )	( )	( )	( )
25 lbs	( )	( )	( )	( )
50 lbs.	( )	( )	( )	( )

Patient's Signature _____ Date _____

DOCTOR'S LIEN

TO:_____
_____
_____

180° Chiropractic & Wellness Center
4091 Mallory Lane, Suite 114
Franklin, TN 37067

Re: Medical Reports and Doctor's Lien

I do hereby authorize the above doctor to furnish you with a report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from settlement, judgment, or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment, or verdict which may be paid to you or myself as the result of the injuries for which I have been treated or injuries in connection herewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

Dated:_____ Patient's Signature:_____

The undersigned does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor above named.

This lien does not constitute a request or agreement between the parties for the attorney or law firm to act as a collection agency for the above-named doctor/doctor's office.

Dated:_____ Patient's Signature:_____

Please date, sign and return one copy
Keep one copy for your records