WORK ACCIDENT INFORMATION

Patient Name ____

Is this visit related to a **work accident**? □ Yes □ No
Date of Accident: ______________________________ Claim #: _________________________
MCO Name __________________________________ Attorney Name ____________________
Please describe in detail the accident use the back of this sheet if needed) _____________________
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Please answer the following questions only if you were injured in an automobile accident at work:

1. Were you the: □ driver □ the passenger □ a pedestrian □ on a bicycle □ on a motorcycle

2.Were you: □ hit (by another vehicle) or □ at fault (you caused the accident

3. From which side were you struck: □ behind □ the front □ the right side □ the left side □ the right front
□ the left front □ the right back □ the left back

4. At the time of impact were you: □ stopped □ moving □ walking □ standing still □ running
□ bicycling □ riding a motorcycle □ crossing the street

5. Were you moving at the time of the accident? □ Yes □ No If yes, what was your speed? ___________

6. Was the involved party moving when the accident occurred? □ Yes □ No If yes, what was their speed? _____________

7. Did you have your seat belt on at the time of the accident? □ Yes □ No

8. Was your head turned at the time of the accident? □ Yes □ No If yes, were you looking: □ Forward
□ looking to the right □ looking to the left □ looking behind you □ looking up □ looking down

9. Were you alone at the time of the accident? □ Yes □ No If no, who was with you? ___________________________

10. What parts of your body hit other structures at the time of impact? (check all that apply)
□ Head □Face □ Forehead □ Back of head □ Right TMJ □ Left TMJ □ Right Shoulder □ Left Shoulder □ Right Arm
□ Left Arm □ Right Elbow □ Left Elbow □ Right Wrist □ Left Wrist □ Right Hand □ Left Hand □ Right Leg □ Right Knee
□ Left Knee □ Right Ankle □ Left Ankle □ Right Foot □ Left Foot

11. What structures did you hit? (check all that apply)
□ Steering Wheel □ Windshield □ Side Window □ Door □ Roof □ Dashboard □ Headrest □ Seat □ Floor □ Side of Car
□ Hood of Car □ Bumper □ Trunk □ The Pavement □ Tree □ Another Car □ Another Person □ Another Object □ A Wall

12. How did you feel after the collision? (check all that apply)
□ Stunned □ Disoriented □ Lost Consciousness □ Tightness □ Felt Mild Discomfort □ Felt Moderate Discomfort
□ Felt Severe Discomfort □ Felt Intense Pain □ Frightened □ Felt a Popping and Ripping Sensation □ Went to Hospital

13. Who was cited for the accident? □ Me □ Other Driver

14. Have you had one or more of the following symptoms since your accident?
□ Cannot sleep due to the accident □ having trouble getting to sleep since the accident □ Lost time from work due to the accident
□ Have been depressed since the accident occurred

15. Have you been treated for injuries related to the accident already? □ Yes □ No
If yes, by whom? ______________________________ Did they perform any diagnostic testing? □ Yes □ No

16. Have you lost wages or not been able to work due to the accident? □ Yes □ No