# Work Related Accident Form

905 Remington Dr. | Mattoon, IL 61938
Ph: 217-234-3423 | F: 217-234-3892

Date: ______________

## PATIENT INFORMATION

Patient Name: ____________________________________________ DOB: _______________ Male / Female

Address: ____________________________________________ SSN: ________________

City: ____________________ State: ____ Zip: _________

Home Ph#: (_______) ___________________ Cell Ph#: (_______) _____________________

Medical Doctor: ___________________________ Ph#: (_______) _____________________

### EMPLOYER INFORMATION

Employer Name: ____________________________________________ Supervisor: ________________________

Address: ____________________________________________

City: ____________________ State: ____ Zip: _________

Insurance: ____________________________________________

Adjuster Name: ____________________________________________ Ph#: (_______) _____________________

### HEALTH INSURANCE INFORMATION

Insurance Co: ____________________________________________ Policy #: ___________________________

Address: ____________________________________________ Group #: ___________________________

City: ____________________ State: ____ Zip: _________

Ph#: (_______) ___________________

Insured's Name: ____________________________________________ DOB: ______________

Insured's Employer: ____________________________________________

Insured's Employer Address: ____________________________________________

City: ____________________ State: ____ Zip: _________

## ACCIDENT INFORMATION

Date of Accident: _______________________ Time: ___________ AM or PM

Address where accident occurred: (if other than employers): _________________________________________________

Was your accident directly related to your work? ___________

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

______________________________________________________________________________________________________

______________________________________________________________________________________________________

Was anyone else present during the accident? If so, who? ___________________________________________________

Did you report the accident to your employer? ___________

What recommendations did your employer make just after the accident? ________________________________________

Has this type of accident happened to your before? ___________

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**ACCIDENT INFORMATION CONT.**

To the best of your knowledge, has this accident occurred in your workplace before? __________

In general: Is your job physically stressful? _________

Is your job mentally stressful? _________

Is your work place noisy? _________

Have you changed jobs in the past year?_________

**AFTER INJURY**

Did the accident render you unconscious? If yes, for how long? _______________________________________________

Please describe how you felt immediately after the accident: __________________________________________________

Have you gone to a hospital or seen any other doctor? ________

When did you go? ☐ Just after the accident ☐ The next day ☐ 2+ days after

How did you get there? ☐ Ambulance ☐ Private transportation

Name of facility and/or attending doctor: _________________________________________________________________

Where X-Rays taken ……………………………………………..Yes / No

Was medication prescribed ……………………………………...Yes / No

Have you been able to work since this injury …………………....Yes / No

Are your work activities restricted as a result of this injury……....Yes / No

Is your condition: ☐ Getting worse ☐ Constant ☐ Comes and goes

Indicate the symptoms that are a result of this accident (please circle all that apply):

| | | |
|---|---|---|
| Neck pain | Lower back pain | Mid back pain |
| Headache(s) | Arms/shoulder pain | Leg pain |
| Numb hands/fingers | Numb feet/toes | Blurred vision |
| Irritability | Ears ringing | Dizziness |
| Nausea | Muscle tension | Difficulty sleeping |
| Memory Loss | Fatigue | Chest pain |
| Shortness of breath | Jaw clicking/pain | Facial pain |
| Upset stomach | | |

If any of your medical or account information has changed, please inform the front desk personnel. Please remember you are ultimately responsible for your account.

Printed Name: ______________________________________

Signature: ______________________________________

Date: _____________________