MAYO THERAPY ASSOCIATES

IF YOURS IS AN ACCIDENTAL INJURY PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of Accident: _____ Hour _____ AM PM Location_____

How did the accident occur? ☐ Auto Collision ☐ On the job injury ☐ Other: _____

Please describe the circumstances: _____

_____

_____

If it was an on the job injury, did you report the injury to you Employer? ☐ YES ☐ NO

If Auto Accident, were you: ☐ Driver ☐ Passenger ☐ Pedestrian. # of passengers in car? _____

If Auto collision were you struck from ☐ Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Auto was parked.

Did your car strike the other(s) involved ☐ YES ☐ NO Did the other car strike yours? ☐ YES ☐ NO ☐ Undetermined.

As a result of the accident were traffic citations issued to you? ☐ YES ☐ NO The other driver? ☐ YES ☐ NO

To the driver of your car? ☐ YES ☐ NO Were you wearing seatbelts? ☐ YES ☐ NO Shoulder belts? ☐ YES ☐ NO

List the extent of your injuries as you know them: _____

Did any parts of your body hit the car? ☐ YES ☐ NO, If yes, describe: _____

Bodily injury to the car - a general description: _____

Monetary damage: _____. Did you require hospitalization? ☐ YES ☐ NO Which hospital? _____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

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

Symptoms other than above: _____

Insurance Companies involved: My company: _____ Other company: _____

Do you have PIP coverage as part of your auto insurance? ☐ YES ☐ NO If yes, how much? _____

Have you opened a claim with YOUR insurance company regarding this accident? ☐ YES ☐ NO

Have you been contacted by an insurance adjuster or company representative regarding this claim? ☐ YES ☐ NO

Do you have an attorney that has advised you in this case? ☐ YES ☐ NO Name:_____

Address_____Telephone:_____

Have you lost any days of work? ☐ YES ☐ NO If yes, how many? _____

Anything else we should know? _____

_____ _____

Patient Signature Date *12/09/2014*