
On the Job Injury (Worker's Compensation)

Employer Name: _____ Employer Address: _____
Contact Person: _____ Date Injured: _____ Hour of Injury: _____ a.m./p.m.
Who is your Worker's Compensation carrier? _____ Claim No.: _____
Name of Adjuster: _____ Phone No.: _____ Extn: _____
Where are you hurting as a result of your current injury? _____
How did your injury occur? _____
Where were you working when you were injured (Location)? _____
Did you require post-accident hospitalization? No Yes If yes, name of hospital: _____
Have you lost any days of work? No Yes Dates: _____ Date last worked: _____
Did you report this injury to your foreman or employer? No Yes
Do you have an attorney that has advised you in this case? No Yes
Attorney's name: _____ Address: _____ Phone: _____

Personal Injury (Auto Collision/Other) Essential Information

Date of accident: _____ Hour: _____ a.m./p.m.
Name of insurance company you wish to receive the billing for payment: _____
Adjuster: _____ Claim No.: _____
Address: _____ Phone: _____ Extn: _____
Have they authorized payment for medical/chiropractic expenses? No Yes
Have you been contacted by an insurance adjuster or company representative regarding this claim? No Yes
Did your injuries occur in the course of employment ("on the job")? No Yes
Where are you hurting as a result of your current injury? _____
How did your injury occur? _____
Have you lost any days of work? No Yes Dates: _____ Date last worked: _____
Was a police report filled out? No Yes
Do you have an attorney that has advised you in this case? No Yes
Attorney's name: _____ Address: _____ Phone: _____

Auto Collision

Location of accident: _____
Name of insurance company covering the vehicle that you were a passenger/driver in: _____
Name of insurance company covering the other vehicle: _____
To help us better understand the effects of the accident on your body (spine), please complete the following questions:
Were you: Driver Passenger Pedestrian
Were you struck from: Behind Right side Left side Front Auto was parked
Did your car strike the other (s) involved? No Yes OR Did the other car strike yours? No Yes
Was your car stationary at the time of impact? No Yes
If no, approximately how fast was your car going? Under 5 mph 10-20 mph 25-40 mph Over 40 mph
Was the other car stationary at the time of impact? No Yes
If no, approximately how fast was their car going? Under 5 mph 10-20 mph 25-40 mph Over 40 mph
Did you require post-accident hospitalization? No Yes If yes, name of hospital: _____
Was any other person injured? _____
Anything bizarre happen? (like glasses jerked off face, etc.) _____
Name of the owner of other vehicle (if more than one vehicle was involved) _____
