S Y N Ξ R G Y

ACCIDENT FORM

ABOUT YOU

Today's Date _____/_____/_____

Name: _____

WORK RELATED ACCIDENT

Date of Accident: _____/_____/_____ Time of accident: _____ a.m. or p.m.

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

Give the address where accident occurred: (if other than employer's address)

Was anyone else present during your accident?	□ Yes	□ No
Did you report your accident to your employer?	□ Yes	□ No

What recommendations did your employer make just after your accident?

Has this type of accident happened to you before?	□ Yes	□ No
To the best of your knowledge, has this accident occurred in your workplace before?	□ Yes	□ No

In general:

Is your job physically stressful?	□ Yes	□ No
Is your job mentally stressful?	□ Yes	□ No
Is your workplace noisy?	□ Yes	□ No
Have you changed jobs in the last year?	□ Yes	□ No

AFTER INJURY

Did accident render you unconscious?	□ Yes	□ No

If yes, how long? _____

Please describe how you felt immediately after the accident:

Have you gone to a Hospital or seen any other Doctor?	□ Yes	□ No

When did you go? □ Just after accident □ The next day □ 2 days plus

How did you go? □ Ambulance or □ Private transportation

Name of Hospital and/or Attending doctor:

Was he/she a : □ D.C. □ M.D. □ D.O. □ D.D.S.

SYNERGY

Describe any treatment you received:

Did you get X-ray?	□ 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

Indicate √ the symptoms that are a result of this accident:

□ Dizziness	□ Difficulty sleeping	□ Jaw problems	□ Nausea
□ Memory loss	□ Irritability	□ Arms/shoulder pain	□ Back pain
□ Headaches(s)	□ Fatigue	□ Numb Hands/Fingers	□ Lower back pain
□ Blurred vision	□ Tension	□ Chest pain	□ Back stiffness
□ Buzzing in ear	□ Neck pain	□ Shortness of breath	□ Leg pain
□ Ears ringing	□ Neck stiff	□ Stomach upset	□ Numb Feet/Toes
□ Other			

Is your condition getting worse? □ Yes □ No □ Constant □ Comes & goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful even if only sometimes
Lying on back	□	□	□
Lying on side	□	□	□
Lying on stomach	□	□	□
Sitting	□	□	□
Standing	□	□	□
Stretching	□	□	□
Lovemaking	□	□	□
Walking	□	□	□
Running	□	□	□
Sports	□	□	□
Working	□	□	□
Lifting	□	□	□
Bending	□	□	□
Kneeling	□	□	□
Pulling	□	□	□
Reaching	□	□	□

SYNERGY

RECOVERY

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal work day? _____

Please indicate √ for your daily job duties and any activities which you are occasionally asked to perform.

□ Standing	□ Driving	□ Operating equipment
□ Sitting	□ Twisting	□ Work with arms above head
□ Walking	□ Crawling	□ Typing
□ Lifting	□ Bending	□ Stooping

□ Other _____

What positions can you work in with minimum physical effort and for how long?

_____ □ N/A

Prior to the injury were you capable of working on an equal basis with others your age?

□ Yes □ No □ N/A

Do you work with others who can help you with any heavy lifting? □ Yes □ No □ N/A

While in recovery, is there any light duty work you could request? □ Yes □ No □ N/A

INSURANCE

Type of Insurance: _____

Company Name: _____

Billing Address: _____

Phone #: _____

Insured's Name: _____

Policy #: _____ Claim # _____

Insured's SS #: _____ DOB: _____

Insured's Employer: _____

Agent's Name: _____

Have you retained an attorney? _____

If so, whom? _____ Phone #:_____

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

_____ _____/_____/____

Signature Date