CHICAGO NEUROSCIENCE INSTITUTE

Accident Information

If your condition is related to an accidental injury, please complete the following.

Patient Name: ______________________ Date: __________

Date of accident: __________

Time: ________ ☐ am ☐ pm Location: ______________

How did the accident occur? ☐ Auto collision ☐ On-the-job injury ☐ Other

____

Please describe the accident: ______________________________

____

____

Please list the exact areas of pain after the accident: ______________________________

____

Any prior similar symptoms or complaints: ______________________________

Were you taken to the hospital? ☐ Yes ☐ No Name of hospital:

____

Were you admitted? ☐ Yes ☐ No What treatment was given? ______________

Has the injury restricted your work or activities of daily living? ☐ Yes ☐ No Explain: ______________

____

Have you lost any days of work? ☐ Yes ☐ No Dates: ______________

Workers Compensation

Did you report the injury to your employer? ☐ Yes ☐ No If yes name of person notified: ______________

Has your employer authorized treatment? ☐ Yes ☐ No If yes name of person: ______________

After your accident, did you return to work? ☐ Yes ☐ No

Have you had a workman's compensation claim before? ☐ Yes ☐ No Year: ______________

Automobile Accident

Were you ☐ Driver ☐ Passenger ☐ Pedestrian

Did your car strike the other car(s) involved? ☐ Yes ☐ No Or did another car strike you? ☐ Yes ☐ No

If you were struck by another vehicle, were you struck from ☐ Behind ☐ Right side ☐ Left side ☐ Front

As a result of the accident, were traffic citations issued to you or the driver of the vehicle you were in? ☐ Yes ☐ No

Were citations issued to the other car(s) driver? ☐ Yes ☐ No

Attorney Information

Do you have an attorney that has advised you in this case? ☐ Yes ☐ No

If Yes, your attorneys name: ______________________ Phone: ______________

Attorneys address: ______________________________

City: ______________________ State: ______________ Zip: ______________