4307 Ball Camp Pike
Knoxville, TN 37921
865-524-1234
865-524-2169 fax

312 Prosperity Drive, Ste. 101
Knoxville, TN 37923
865-691-3155
865-694-8093 fax

Name: ______________________________________ Date: __________________ Chart#: _______________

## ACCIDENT INFORMATION (this section must be completed)

Please describe, in detail, how the accident happened: ____________________________________________
______________________________________________________________________________________
Date of accident: _______________________ Time: _______________ AM / PM
Where did the injury occur? __________________________________________
Did you go to the hospital? ☐ **Yes** ☐ **No**
Did you go to the hospital
**If yes, how did you get there?** ☐ **Ambulance** ☐ **Other:** ______________________________
If by ambulance, did the ambulance attendants place you in a: ☐ **Neck brace** ☐ **Back brace**
☐ **Other** _____________________________________
**Hospital Name** _______________________________ **Doctor Name** ___________________________
Did you have: ☐ **X-rays** ☐ **MRI** ☐ **CT Scan**

Have you retained an attorney? ☐ **Yes** ☐ **No** **Litigation?** ☐ **Yes** ☐ **No** ☐ **Maybe**
If yes, please give name and address: ____________________________________________________________

## AUTO (complete this section only, if you were involved in an auto accident)

Where did the collision occur? **City/Town:** ________________________________ **State:** ____________________
Were you the: ☐ **Driver** ☐ **Passenger** ☐ **Pedestrian**
What type of vehicle were you in? _____________________What type was the other vehicle? __________________
Was there a second impact? ☐ **Yes** ☐ **No** **If so, explain** ______________________________________________
Was the impact from: ☐ **Front** ☐ **Rear** ☐ **Left Side** ☐ **Right Side**
What was the approximate speed at the time of impact? **Your Vehicle** ______ **mph** **Other Vehicle** _____**mph**
How much damage was there to the outside of the vehicle? ☐ **None** ☐ **Some** ☐ **Major**
Were you wearing a seat belt? ☐ **Yes** ☐ **No**
Does your vehicle have an airbag? ☐ **Yes** ☐ **No** Did it deploy? ☐ **Yes** ☐ **No**
Immediately after the accident, where did you experience pain? **(be specific)** ______________________________
Immediately after the accident, were you? ☐ **conscious** ☐ **dazed** ☐ **unconscious, if so how long?** _____________
Were you surprised by the impact? ☐ **Yes** ☐ **No**

## PERSONAL INJURY (complete this section only, if you were involved in personal injury accident)

Was there anything in particular that your think caused the injury: **example-wet floor**
Please describe: _______________________________________________________________________________
______________________________________________________________________________________
Immediately after the accident were you: ☐ **conscious** ☐ **dazed** ☐ **unconscious, if so how long?** ______________
Did anyone witness your injury? ☐ **Yes** ☐ **No** **Who?** ______________________________________________
Was the report: ☐ **Written** ☐ **Verbal**
Did you have any physical complaints **just before the injury**? ☐ **Yes** ☐ **No**
**Explain:** ____________________________________________________________________________________
What type of work do you do/requirements? _____________________________________________________
Have you lost any days of work because of this injury? ☐ **Yes** ☐ **No**
**If yes, date(s):** ______________________________________________________

**OVER** ⟶

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**WORKERS COMP** (complete this section only, if you were involved in an accident at work)

What address were you at when injured? ____________________________________________________________
What injuries did you suffer? ______________________________________________________________________
____________________________________________________________________________________________
Since the injury, are you symptoms? ☐ **Improving** ☐ **Getting Worse** ☐ **Same**
Are your work activities restricted as a result of this accident? ☐ **Yes** ☐ **No**
Did you notify your employer of this injury? ☐ **Yes** ☐ **No** **With whom did you speak?** ______________________
Did you return to work? ☐ **Yes** ☐ **No** **If Yes, date returned: ____/_____/______**
**If No, date last worked: ____/_____/______**
Did you consult another doctor? ☐ **Yes** ☐ **No** **If yes, date consulted: ____/_____/______**
**Doctor's Name** ____________________________________________ ☐ **DC** ☐ **MD** ☐ **DO** ☐**DDS**
Diagnosis or treatment: ______________________________________________________________________
Have you ever injured this area before? ☐ **Yes** ☐ **No**
If injured before, did you lose time from work? ☐ **Yes** ☐ **No**
If you lost time from work with injuries prior to this injury, give names and doctors consulted: ___________________
____________________________________________________________________________________________
Other diseases or accidents affect your employment? ☐ **Yes** ☐ **No**
**If so, explain** ______________________________________________________________________________
In your work, do you have to favor any part of your body? ☐ **Yes** ☐ **No**
**If so, explain** ______________________________________________________________________________
Any history of absenteeism caused from accidents on the job? ☐ **Yes** ☐ **No**
Ever had a worker's compensation claim before? ☐ **Yes** ☐ **No**
Before the injury were you capable of working on an equal basis with others your age? ☐ **Yes** ☐ **No**

Patient Signature: _____________________________________________ Date: ______________________