MAINE CHIROPRACTIC
HEALTH CLINIC

Luc J. Dionne D.C.

"We are committed to excellence"

Physical Therapy
Massage Therapy

AUTO/WORK RELATED ACCIDENT

ABOUT YOU

Today's Date: ___/___/___ File #: ____________

Name: ______________________________

WORK RELATED ACCIDENT

Date & Time of Accident: ____________ ❑ a.m. ❑ p.m.

Was your accident directly related to your work? ❑ Yes ❑ No

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

AUTO RELATED ACCIDENT

Date & Time of Accident: ____________ ❑ a.m. ❑ p.m.

Were you the: ❑ Driver ❑ Front Passenger ❑ Rear Passenger

If a traffic violation was issued, to whom was it issued? ______________________________

Number of people in accident vehicle? ____________

Did the police come to the accident site? . . ❑ Yes ❑ No

Was a police report filed? . . . . ❑ Yes ❑ No

Were there any witnesses? . . . . ❑ Yes ❑ No

Were you wearing your seat belt? . . . . ❑ Yes ❑ No

Was this vehicle equipped with airbags? . . ❑ Yes ❑ No

If yes, did it/they inflate? . . . . ❑ Yes ❑ No

In relation to the base of your skull, where was the headrest? . . . . . . ❑ Above ❑ Below ❑ At base of skull

What did your vehicle impact? ❑ Another vehicle ❑ Other

If other, explain: ______________________________

Did any part of your body strike anything in the vehicle? ❑ Yes ❑ No

If yes, please describe: ______________________________

Make & model of the vehicle you were occupying? ______________________________

Name of the location/street on which you were traveling? ______________________________

In which direction were you headed? ❑ N ❑ S ❑ E ❑ W

What was the approx. speed of your vehicle? ____________

Did the impact to your vehicle come from the:
❑ Front ❑ Rear ❑ Right Side ❑ Left Side ❑ Other

During impact, were you facing: ❑ Right ❑ Left ❑ Forward

Were you ❑ aware or ❑ surprised by the impact?

If accident vehicle made impact with another vehicle...

Make and model of that other vehicle? ______________________________

Direction other vehicle was headed? ❑ N ❑ S ❑ E ❑ W

Speed of the other vehicle? ____________

In your words, please describe the accident: ______________________________

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