

Please fill out if you were involved in a **work-related incident** or **motor vehicle accident**. Thank you.

Date of injury:

MVA _____ WRI _____ Litigation: Yes No

What was your last day of work? _____

If **MVA**, were you the driver? Yes No

Did you have a seatbelt on? Yes No

What type of vehicle and year: _____

What was the amount of damage to the vehicle: _____

If **WRI**, Did you report to your supervisor? Yes No If Yes, Date: _____

Description of incident/accident:

What complaints did you have immediately after the incident/accident? _____

Did you go to the ER? Yes No

If Yes Date: _____ Hospital: _____

Did you lose consciousness? Yes No

When and where did you seek treatment after the incident/accident? _____

Did you have a history of problems prior to your incident? Yes No

If Yes, When _____ What area of the body? _____

Films of the area obtained, in the past? Yes No When? _____

What treatment did you have before the incident/accident? _____
