



North/Central Office: 4307 Ball Camp Pike • Knoxville, TN 37921 • t 865.524.1234 • f 865.524.2169

West Office: 312 Prosperity Drive, Ste. 101 • Knoxville, TN 37923 • t 865.691.3155 • f 865.694.8093

Sutherland Office (In Cherokee Mills/Square One):

2270 Sutherland Ave • Knoxville, TN 37919 • t 865.770.5558 • f 865.524.2169

www.applehealthcaregroup.com

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  
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):** \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For Office Use Only: MRN#: \_\_\_\_\_

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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: \_\_\_\_\_