PERSONAL INJURY PATIENT HISTORY

Please write legibly

Name_____ File #_____ Date_____

30 HISTORY OF OCCURENCE

10 Date of Accident_____ Time_____ ☐ AM ☐ PM

Driver of car:_____ Where were you seated? _____

Who owns the car?_____ Year and model of car: _____

What was the approximate damage done to the car you were in? $ _____

20 Visibility at time of accident: ☐ Poor ☐ Fair ☐ Good

Road conditions at time of accident: ☐ Icy ☐ Rainy and ☐ Wet ☐ Clear ☐ Dark

Your car: ☐ Hit another car ☐ Was hit in the: ☐ Right ☐ Left ☐ Rear ☐ Front ☐ Side

Type of accident: ☐ Head on collision ☐ Broad side collision

☐ Rear-end collision ☐ Front impact, rear-ended car in front

☐ Non collision: _____

40 **IMPACT/SEAT BELT/HEADREST/SPEED**

10 Describe in your own words what happened to you upon impact: _____

_____

Did you see the accident coming? ☐ Yes ☐ No

Were you prewarned that the accident was about to happen? ☐ Yes ☐ No

Did you brace for the impact? ☐ Yes ☐ No

Were seat belts worn? ☐ Yes ☐ No

Were shoulder harnesses worn? ☐ Yes ☐ No

20 Does your car have headrests? ☐ Yes ☐ No

30 If yes, what was the position of those headrests compared to your head before the accident?

☐ Top of headrest even with bottom of head ☐ Top of headrest even with top of head ☐ Top of headrest even with middle of neck

40 Was your car braking? ☐ Yes ☐ No

50 Was your car moving at the time of accident? ☐ Yes ☐ No

60 If yes, how fast would you estimate you were going/_____MPH (estimate)

70 How fast was the other car travelling?_____MPH (estimate)

50 HEAD/BODY POSITION/ABLE TO MOVE BODY

10 Head/Body position at time of impact: ☐ Head turned: ☐ Right ☐ Left ☐ Head looking back ☐ Head straight forward

20 At the time of accident, recall what parts of your head or body hit what parts on the inside of your car: _____

_____

30 As a result of the accident you were: ☐ Rendered unconscious ☐ Dazed, circumstances vague ☐ Shaken up but could function

40 Could you move all parts of your body? ☐ Yes ☐ No

50 If no, what parts and why? _____

60 Were you able to get out of the car and walk unaided? ☐ Yes ☐ No

70 If no, why not?_____

60 **SYMPTOMS FROM ACCIDENT**
10 Did you get bleeding cuts or bruises? ☐ Yes ☐ No

20 If yes, what bleeding cuts did you get from this accident? _____

If yes, what bruises did you get from this accident? _____

30 Please describe how you felt. *PLEASE BE SPECIFIC.*

Immediately after the accident: _____

40 Later that ☐ Day ☐ Night: _____

50 The next day(s): _____

60 Check symptoms apparent since the accident:

☐ Headache	☐ Dizziness	☐ Loss of memory	☐ Sleeping problems	☐ Constipation
☐ Neck pain/stiffness	☐ Fainting	☐ Fatigue	☐ Numbness in toes	☐ Chest pain
☐ Midback pain	☐ Ringing/buzzing ears	☐ Tension	☐ Numbness in fingers	☐ Nervousness
☐ Low back pain	☐ Loss of balance	☐ Shortness of breath	☐ Cold hands	☐ Cold sweats
☐ Eyes sensitive to light	☐ Loss of smell	☐ Irritability	☐ Cold feet	☐ Anxious
☐ Pain behind eyes	☐ Loss of taste	☐ Depression	☐ Diarrhea	☐ Other _____

70 **WORK STATUS HISTORY**
10 Occupation: _____ Employer: _____

20 Have you missed time from work? ☐ Yes ☐ No

30-40 If yes: Full time off work _____ to _____ to _____

Part-time off work _____ to _____ to _____

60 ☐ Been unable to work since accident.

80 **FIRST DOCTOR/HOSPITAL/CLINIC SEEN**
10 Did you go to seek medical help immediately/soon after the accident? ☐ Yes ☐ No

If yes, how did you get there? ☐ Someone else drove me ☐ Drove own car ☐ Ambulance ☐ Police

DOCTOR/HOSPITAL/CLINIC SEEN: _____ Date of first visit: _____

20 Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

30 Were you given treatment? ☐ Yes ☐ No

40 If yes, what treatment was given to you? _____

What benefits did you receive from the treatment? _____

50 Date of last treatment: _____

90 **SECOND DOCTOR/CLINIC SEEN**
10 Did you go to seek medical help immediately/soon after the accident? ☐ Yes ☐ No

If yes, how did you get there? ☐ Someone else drove me ☐ Drove own car ☐ Ambulance ☐ Police

DOCTOR/HOSPITAL/CLINIC SEEN: _____ Date of first visit: _____

20 Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

30 Were you given treatment? ☐ Yes ☐ No

40 If yes, what treatment was given to you? _____

What benefits did you receive from the treatment? _____

50 Date of last treatment: _____

100 **THIRD DOCTOR/CLINIC SEEN**
10 Did you go to seek medical help immediately/soon after the accident? ☐ Yes ☐ No

If yes, how did you get there? ☐ Someone else drove me ☐ Drove own car ☐ Ambulance ☐ Police

DOCTOR/HOSPITAL/CLINIC SEEN: _____ Date of first visit: _____

20 Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

30 Were you given treatment? ☐ Yes ☐ No

40 If yes, what treatment was given to you? _____

What benefits did you receive from the treatment? _____

50 Date of last treatment: _____

110 PRIOR SIMILAR SYMPTOMS

10 Did you have any physical complaints just before the accident? ☐ Yes ☐ No

20 If yes, please describe in detail: _____

30 PRIOR to this accident, have you EVER had symptoms similar to what you're experiencing now? ☐ Yes ☐ No

40 If yes, please explain *(briefly include past falls, injuries, accidents, operations, etc.)*: _____

_____

120 ACTIVITIES OF DAILY LIVING

10 Do you notice any activities of your home daily routines that are different now than from before the accident? ☐ Yes ☐ No

20 If yes, list them as: _____

30 Those activities that you are unable to do are *(be specific)*: _____

40 Those activities that are painful to do are *(be specific)*: _____

50 Those activities that are difficult to do are *(be specific)*: _____

130 PAIN LEVEL/SCALE OF RECOVERY

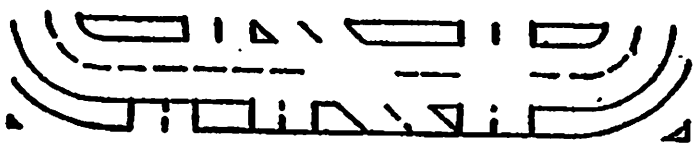
10 On a scale of 0-10, with 0 being (examiner's quote), *"You're pain free and can function quite well,"* and 10 being, *"You're in pain all the time and cannot function at all,"* where would you rate yourself?

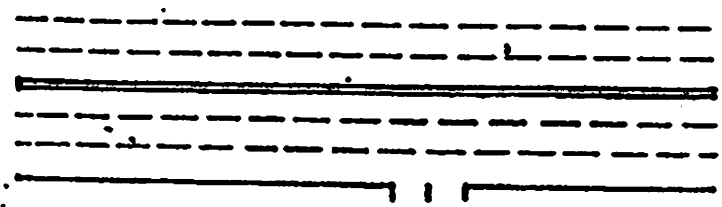
NORMAL	LOW PAIN			MODERATE PAIN			INTENSE PAIN			EMERGENCY
0	1	2	3	4	5	6	7	8	9	10

Please explain why: _____

20 Relative to where you were before this injury, how would you rate how much you have recovered so far? _____%

INDICATE ON THESE DIAGRAMS HOW THE ACCIDENT HAPPENED





ATTORNEY ON CASE

Do you have an attorney on this case? ☐ Yes ☐ No

If yes, who? Name _____

Address _____ City _____ State _____ Zip _____

Patient Signature: _____ Date _____

AUTOMOBILE ACCIDENT — INSURANCE DATA

Patient's Insurance Company Information

Company Name: _____ PH: _____ Claim #: _____

P.O. Box/Street Number: _____ Adjuster's Name: _____

City/State/Zip: _____

Insured's Insurance Information

Insured's name if other than patient: _____ PH: _____

Company Name: _____ PH: _____ Policy #: _____

P.O. Box/Street Number: _____ Adjuster's Name: _____

City/State/Zip: _____

Other Driver's Insurance Information

Other Driver's Name (if another car was involved): _____ PH: _____

Company Name: _____ PH: _____ Policy#: _____

P.O. Box/Street Number: _____ Adjuster's Name: _____