

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:
- | | | | | |
|--|---|--|--|---------------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Neck pain/stiffness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Midback pain | <input type="checkbox"/> Ringing/buzzing ears | <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Eyes sensitive to light | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Irritability | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Anxious |
| <input type="checkbox"/> Pain behind eyes | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Depression | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> 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

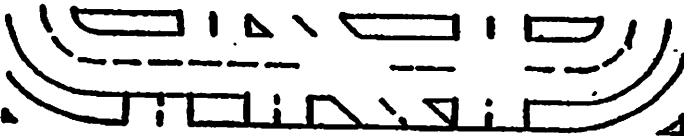
10 On a scale of 0-10, with 0 being (examiner's quote), "You're pain free and can function quite well," and 10 being, "You're in pain all the time and cannot function at all," where would you rate yourself?

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: _____