Willoughby
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PERSONAL INJURY HISTORY

Date: ________________

Name: ____

Phone: ________________

Address:
____
____

Age: __________ **Social Security Number:** ______________________

Employer: ____

Employer Phone Number: ____________________

Employer Address: ____
____
____

Occupation: _______________________________

Referred By: _______________________________

Date of Injury: _____________________________

***History*: (describe accident)**

___ Driver ___ Passenger in front seat
___ Pedestrian ___ Passenger in rear seat
___ Other ____

Were you either:
___ In-motion ___ Stopped

Direction heading:
___ North ___ South ___ East ___West

Location:
Street: ___________________ City ____________ State:________

Were you wearing a seat belt:
___ Yes ___ No

***DESCRIPTION OF ACCIDENT*: (check or circle appropriate description)**

___ Stopped/Slowing down for (traffic/red light/stop sign) and was struck in the rear by another vehicle.

___ **Was pushed into the vehicle in front of his/hers.**

___ **Slowing down to execute a turn and was struck in the rear by another vehicle.**

___ **Was side swiped by another vehicle traveling in the same direction.**

___ **Another vehicle traveling in the opposite direction collided head-on with the vehicle in which you were riding.**

___ **Another vehicle traveling in the opposite direction suddenly turned in front of your vehicle causing the two vehicles to collide.**

___ **Another vehicle made an improper turn and caused the two vehicles to collide.**

___ **Another vehicle ran a (red light/stop sign) and struck (his/her) vehicle (broadside/in the rear/in the front end).**

___ **The vehicle in which you were riding was struck by another vehicle causing it to (spin around/roll over).**

___ **You were involved in a multi-care collision.**

___ **You were involved in a motor vehicle collision.**

___ **The driver of the vehicle in which you were riding lost control and (struck another vehicle/ran off the road/struck an object - : describe ____).**

___ **You were thrown from the car to the pavement.**

___ **You were a (pedestrian/riding a bicycle/riding a motorcycle) and was struck by a motor vehicle.**

___ **Other (brief description) ____**
____

Did you strike any objects in the car? ____ Yes ____ No

If yes, select the objects that were struck:

__ Windshield	__ Rear window of pick up
__ Headrest	__ Back of seat
__ Dash board	__ Seat broke
__ Steering wheel	__ door frame
__ Rear view mirror	__ Side window
__ Jarred or was thrown about	__ Dazed cannot remember d etails

Select from the following list, the part or parts of the body that struck the object:

__ Head	__ Shoulder(s) rt/lt	__ Arm(s) rt/lt	__ Elbow(s) rt/lt
__ Face	__ Wrist(s) rt/lt	__ Leg(s) rt/lt	__ Knee(s) rt/lt
__ Chest	__ Neck	__ Back	__ Other___ _______________

Were you:

- __ Unconscious
- __ Cut or bleeding (describe)____
- __ Neither

If applicable, indicate any pain or abnormal sensations experienced immediately following the accident:

- __ Felt no immediate pain
- __ Head pain
- __ Semi -conscious
- __ Mid back pain R/L
- __ Low back pain R/L
- __ Pain began several hours after the accident
- __ Pain began shortly after accident
- __ Neck pain R/L
- __ Lower extremity pain
- __ Other ____________________ __________

Indicate the action taken immediately following the accident:

- __ Went home and took it easy
- __ Went about normal business
- __ Went home and (shortly after/later that night/the following morning) began to experience (neck/midback/low back) pain.
- __ Went home and later (drove/was driven) to ________________hospital
- __ Doctored myself thinking the pain would go away
- __ Went to physician
- __ Was taken to the hospital by ambulance.

Hospitalization: **(IF NONE, SKIP TO TREATING PHYSICIANS NEXT PAGE)**

Indicate method of transportation to hospital:

- __ Ambulance
- __ Drove
- __ Was driven
- __ Went home and was later taken or driven to the hospital

Name of hospital: ____________________________ City:__________________________

Were you seen in the emergency room? Yes No

Were you admitted to the hospital? Yes No

Length of stay:____

Name of admitting physician:____

Indicate any procedures performed at the hospital (including emergency room) or other physician:

- __ Examination
- __ X-rays
- __ MRI/CT
- __ Complete Bed rest
- __ Stitches
- __ Ice
- __ Injection
- __ Other ______________________________________
- __ Cervical Collar
- __ Wounds Dressed
- __ Prescription

Following your release from the hospital you:

- __ Returned home and took it easy
- __ Returned home and went to bed
- __ Returned home and returned to the emergency room after ___ hrs/dys
- __ Returned to work

Treating Physicians:

When did you first consult a physician? ____

Name of physician?___________________________

Treatments/Medications from physician?____

How long were you under the care of a doctor?:_______________________________________

Are you still being treated by a doctor? Y/N, if yes how often?______________________________

List any and all present treatments (meds, ice, heat, physical therapy, etc.)__________________

____

Past History:

Have you ever been involved in any previous accidents or injuries of any kind? Yes/No

If yes, give dates and details:

____

____

____

Have you been treated for same or similar symptoms in the past? Please explain:

____

____

____

List any significant medical problems: (Diabetes, heart, lungs, B/P, ect.)

____

____

Did you enjoy good health prior to this accident? Yes/No

List all activities that have been affected by your injuries due to the accident. Example (sports, social, and work activities, relationships, Housework, etc.) Explain HOW they have been affected:

____

____

____

PRESENT COMPLAINTS:

What are your present complaints, beginning with the most severe? (Circle one out of each group)

1.________________________________ (constant or occasional) (mild, moderate or severe)

2.________________________________ (constant or occasional) (mild, moderate or severe)

3.________________________________ (constant or occasional) (mild, moderate or severe)

4.________________________________ (constant or occasional) (mild, moderate or severe)

On a pain scale from 1 to 10 (one being mild and 10 being severe) how would you rate your overall condition? ______________

Please CHECK all activities that are painful to perform:

__Sitting __Standing __Lying Down __Movement __Rest

__Use __Walking __Running __Work Activities __Housework

Symptoms are more noticeable:

__Morning __Evening __Afternoon __Sleeping

DISABILITY:

Have you lost any time from work since the accident? Yes/No
If yes, how many days, weeks or months? ________________________
Are you still off from work? Yes/No
If yes give estimated return to work date: ________________________
Are you working with restrictions? Yes/No
If yes, list restrictions:____
____

INSURANCE INFORMATION (if available)

Your Automobile Insurance Company Name:

____

Phone Number: ________________________

Claim No:______________________________

Address:________________________________
____

Adjuster: _______________________________