WRITE LEGIBLY

PERSONAL INJURY PATIENT HISTORY

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Name _____ Date _____ File# _____

30 HISTORY OF OCCURRENCE

10 Date of Accident: _____ Time: _____ ❑ AM ❑ PM

Driver of car: _____ What seat were you sitting in? _____

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: _____

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

❑ Body straight in sitting position ❑ Body rotated: ❑ Right ❑ Left

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 body parts could you not move and why? _____

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

70 If no, why couldn't you get out of the car and walk unaided? _____

60 SYMPTOMS FROM ACCIDENT

10 Did you get bleeding cuts or bruises? ❑ 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 _____

50 If Yes: Part-time off work _____

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 1/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 DOCTOR 2/HOSPITAL/CLINIC SEEN: _____ Date of first visit: _____

Were you examined? ❑ Yes ❑ No Were X-rays taken? ❑ Yes ❑ No

20 Were you given treatment? ❑ Yes ❑ No

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

What benefits did you receive from the treatment? _____

40 Date of last treatment: _____

100 THIRD DOCTOR/CLINIC SEEN

10 DOCTOR 3/HOSPITAL/CLINIC SEEN: _____ Date of first visit: _____

Were you examined? ❑ Yes ❑ No Were X-rays taken? ❑ Yes ❑ No

20 Were you given treatment? ❑ Yes ❑ No

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

What benefits did you receive from the treatment? _____

40 Date of last treatment: _____

110 PRIOR SIMILAR SYMPTOMS

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

20 If yes, what physical symptoms did you have **just before the accident?** _____

_____

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

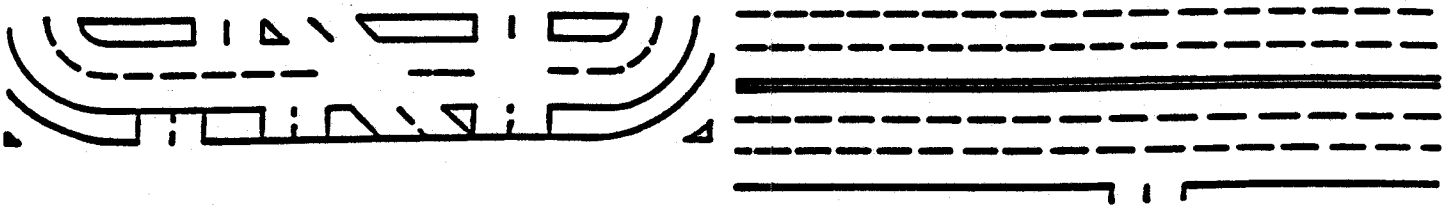
20 If yes, list them as:

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

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

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

INDICATE ON THESE DIAGRAMS HOW THE ACCIDENT HAPPENED



Patient Signature: _____ Date: _____