WRITE LEGIBLY

PERSONAL INJURY PATIENT HISTORY

WRITE LEGIBLY

NAME_____DATE_____FILE#_____

30 HISTORY OF OCCURRENCE

10 Date of Accident:_____ Time:_____ ☐ AM ☐PM Driver of Car: _____
Where were you seated? ☐Driver's seat ☐Front right passenger ☐Front middle passenger
☐Rear right passenger ☐Rear middle passenger ☐Rear left passenger
Who owns the car?_____ Year and model of car: _____
15 What was the damage done to the car you were in? ☐Mild ☐Moderate ☐Severe ☐Total ☐Unknown
Visibility at time of accident: ☐Poor ☐Fair ☐Good
Road conditions at time of accident: ☐Snow/Icy ☐Wet ☐Clear ☐Dark
Type of accident: ☐Was hit in the ☐Hit another car in the ☐Rear ☐Right side ☐Left side ☐Front

☐Non-collision: (Describe)_____

40 IMPACT/SEAT BELT/HEADREST/SPEED

10 Describe in your own words what happened to you upon impact: _____
Were you aware the accident was about to happen? ☐Yes ☐No
Did you brace for the impact? ☐Yes ☐No
Were you wearing a seat belt/shoulder harness? ☐Yes ☐No
20 Did the car you were in have a headrest? ☐No
30 If yes, what was the position of the headrest compared to your head before the accident?
☐Top of headrest even with **bottom** of the head ☐Top of headrest even with **top** of the head
☐Top of headrest even with **middle** of the neck
35 Was the car equipped with an airbag where you were seated? ☐No
36 If yes did the airbag inflate? ☐Yes ☐No
37 Were you injured by the inflated airbag? ☐No
38 If yes, what were the injuries? _____
40 Was your car braking? ☐Yes ☐No
50 Was your car moving at the time of the accident? ☐No
60 If yes, how fast would you estimate you were going? _____MPH (estimate)
70 How fast was the other car traveling? _____MPH (estimate) ☐Don't know

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 the 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 were you: ☐Rendered unconscious ☐Dazed, circumstances vague
☐Shaken up but could think clearly and function
40 Could you move all parts of your body? ☐Yes
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
70 If no, why couldn't you get out of the car and walk unaided? _____
80 Did you receive any medical assistance at the scene of the accident? ☐Yes ☐No

60 SYMPTOMS FROM ACCIDENT

10 Did you get any 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 Over the next days: _____

60 Check symptoms apparent **since** the accident:

☐ Headache	☐ Dizziness	☐ Loss of memory	☐ Sleeping problems	☐ Constipation
☐ Neck pain/stiffness	☐ Fainting	☐ Fatigue	☐ Numb toes	☐ Chest pain
☐ Midback pain	☐ Ringing in ear	☐ Tension	☐ Numb 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	

70 WORK STATUS HISTORY

10 Employer: _____Occupation: _____

20 Have you missed time from work? ☐No

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

50 If yes: Part time off work: _____

60 ☐Been unable to work since the accident.

80 FIRST DOCTOR/HOSPITAL/CLINIC SEEN

10 Did you go to seek medical help immediately/soon after the accident? ☐No

15 If yes, who first treated you? DOCTOR 1/HOSPITAL/CLINIC:_____Date of 1st visit: _____

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

30 Were you given treatment? ☐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/CLINIC: _____Date of first visit:_____

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

20 Were you given treatment? ☐No

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

40 Date of last treatment: _____

100 THIRD DOCTOR/CLINIC SEEN

10 DOCTOR 3/CLINIC: _____Date of first visit:_____

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

20 Were you given treatment? ☐No

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

40 Date of last treatment: _____

110 PRIOR SIMILAR SYMPTOMS

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

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

_____

120 ACTIVITES OF DAILY LIVING

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

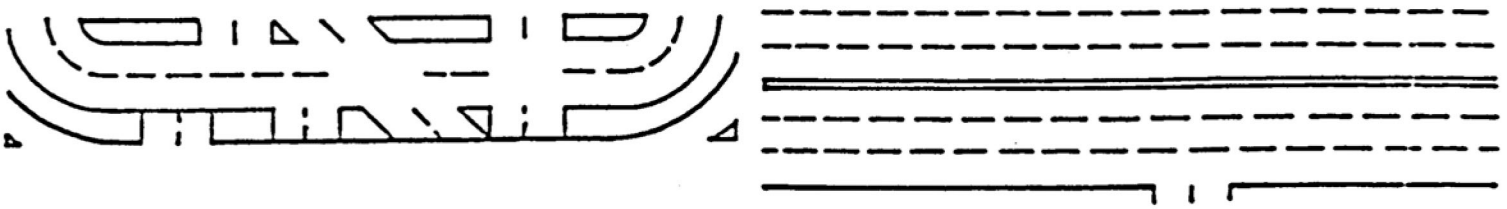
20 If yes, list them as:

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 THIS DIAGRAM HOW THE ACCIDENT HAPPENED – (NOTE THE CAR YOU WERE IN AS CAR "A")



ATTORNEY ON CASE

Do you have an attorney on this case? ☐No

If yes, who? Name: _____ Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Patient Signature: _____ Date: _____

AUTOMOBILE ACCIDENT – INSURANCE DATA

Patient's Insurance Company Information – (you)

Company Name: _____ Policy #: _____ Claim#: _____

Address: _____ City: _____ State: ____ Zip: _____

Adjuster's Name: _____ Phone: _____

Insured's Insurance Information – (Driver of car you were in – if not you)

Insured's name if other than you: _____ Phone: _____

Adjuster's Name: _____ Phone: _____

Company Name: _____ Policy #: _____ Claim#: _____

Address: _____ City: _____ State: ____ Zip: _____

Other Driver's Insurance Information – (Other car's driver)

Insured's name if other than you: _____ Phone: _____

Adjuster's Name: _____ Phone: _____

Company Name: _____ Policy #: _____ Claim#: _____

Address: _____ City: _____ State: ____ Zip: _____