

# PERSONAL INJURY PATIENT HISTORY

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Name: \_\_\_\_\_ Date: \_\_\_\_\_ File # \_\_\_\_\_

## HISTORY OF OCCURRENCE

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: \_\_\_\_\_

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 for 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) \_\_\_\_\_  
\_\_\_\_\_

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## IMPACT/SEAT BELT/HEADREST/SPEED

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 your seat belt/shoulder harness?  Yes  No

Did the car you were in have a headrest?  Yes  No

If yes, what was the position of the headrest 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

Was the car equipped with an airbag where you were seated?  Yes  No

If **yes** did the airbag inflate?  Yes  No

Were you injured by the inflated airbag?  Yes  No

If **yes**, what were the injuries? \_\_\_\_\_

Was your car braking?  Yes  No

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

If **yes**, how fast would you estimate you were going? \_\_\_\_\_ MPH (estimate)

How fast was the other car traveling? \_\_\_\_\_ MPH (estimate)  Don't know

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## HEAD/BODY POSITION/ABLE TO MOVE BODY

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

At the time of accident, recall what parts of your **head** or **body** hit what parts on the inside of your car: \_\_\_\_\_  
\_\_\_\_\_

As a result of the accident you were:  Rendered unconscious  Dazed, circumstances vague

Shaken up but could think clearly and function

Could you move all parts of your body?  Yes  No

If **no**, what body parts could you not move and why? \_\_\_\_\_

Did you receive any medical assistance at the scene of the accident?  Yes  No

## SYMPTOMS FROM ACCIDENT

Did you get any bleeding cuts or bruises?  Yes  No

If **yes**, what **bleeding cuts** did you get from this accident? \_\_\_\_\_

If **yes**, what bruises did you get from this accident? \_\_\_\_\_

Please describe how you felt. PLEASE BE SPECIFIC

Immediately after the accident: \_\_\_\_\_

Later that  Day  Night: \_\_\_\_\_

Over the next days: \_\_\_\_\_

Check symptoms apparent **since** the accident:

- |  |  |  |   |                                       |
|--|--|--|---|---------------------------------------|
| <input type="checkbox"/> Headache                | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Loss of memory      | <input type="checkbox"/> Sleeping problem | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Neck pain/stiffness     | <input type="checkbox"/> Fainting        | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Numb toes        | <input type="checkbox"/> Chest pain   |
| <input type="checkbox"/> Midback Pain            | <input type="checkbox"/> Ringing in ear  | <input type="checkbox"/> Tension             | <input type="checkbox"/> Numb 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         |                                       |

## WORK STATUS HISTORY

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Have you missed time from work?  Yes  No

If **yes**: Full time off work: \_\_\_\_\_

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If **yes**: Part time off work: \_\_\_\_\_

Been unable to work since the accident.

## FIRST DOCTOR/HOSPITAL/CLINIC SEEN

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

If **yes**, who first treated you? DOCTOR/HOSPITAL/CLINIC: \_\_\_\_\_ Date of 1<sup>st</sup> visit: \_\_\_\_\_

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

Were you given treatment?  Yes  No

If **yes**, what treatment was given to you? \_\_\_\_\_

What benefits did you receive from the treatment? \_\_\_\_\_

Date of last treatment: \_\_\_\_\_

## SECOND DOCTOR/CLINIC SEEN

DOCTOR 2/CLINIC: \_\_\_\_\_ Date of 1<sup>st</sup> visit: \_\_\_\_\_

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

Were you given treatment?  Yes  No

If **yes**, what treatment was given to you? \_\_\_\_\_

What benefits did you receive from the treatment? \_\_\_\_\_

Date of last treatment: \_\_\_\_\_

## THIRD DOCTOR/CLINIC SEEN

DOCTOR 3/CLINIC: \_\_\_\_\_ Date of 1<sup>st</sup> visit: \_\_\_\_\_

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

Were you given treatment?  Yes  No

If **yes**, what treatment was given to you? \_\_\_\_\_

What benefits did you receive from the treatment? \_\_\_\_\_

Date of last treatment: \_\_\_\_\_

## PRIOR SIMILAR SYMPTOM

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

If **yes**, what physical symptoms did you have **just before the accident**? \_\_\_\_\_

**PRIOR** to this accident, have you **EVER** had symptoms similar to what you're experiencing now?

Yes  No

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

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## ACTIVITIES OF DAILY LIVING

Do you notice any of your **home** activities that are different **now** than from **before** the accident?

Yes  No

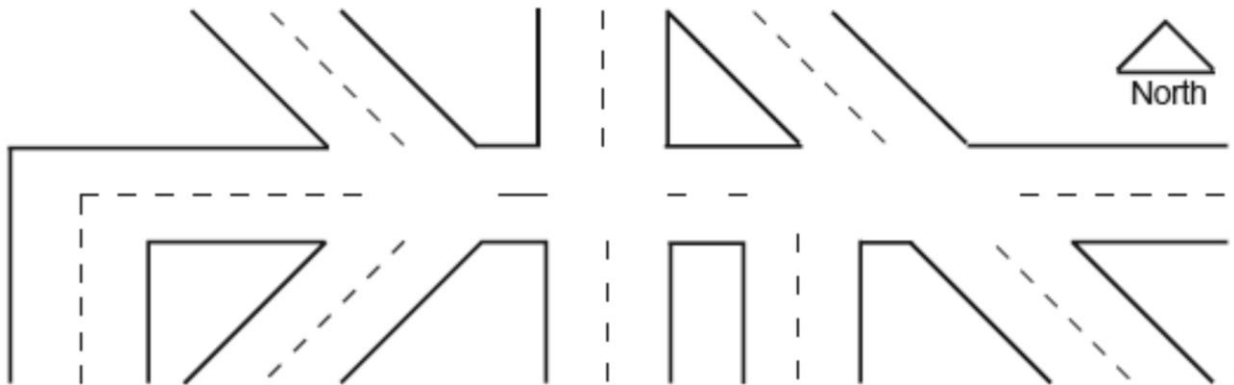
If **yes**, list them as:

Those activities that you are **now unable** to do are (be specific): \_\_\_\_\_

Those activities that you are **now painful** to do are (be specific): \_\_\_\_\_

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?  Yes  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 the care you were in --- if not you)

Insured's Name if other than you: \_\_\_\_\_ Phone \_\_\_\_\_

Company Name: \_\_\_\_\_ Policy # \_\_\_\_\_ Claim # \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Adjuster's Name \_\_\_\_\_ Phone: \_\_\_\_\_

### Other Driver's Insurance Information --- (Other car's driver)

Other driver's name : \_\_\_\_\_ Phone \_\_\_\_\_

Company Name: \_\_\_\_\_ Policy # \_\_\_\_\_ Claim # \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Adjuster's Name \_\_\_\_\_ Phone: \_\_\_\_\_