WRITE LEGIBLY

PERSONAL INJURY PATIENT HISTORY

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Patient Name: _____ Date: _____

30 HISTORY OF OCCURRENCE

10 Date of Accident: _____ Time: ____:____ ☐ am ☐ pm Driver of car: _____

Where were you seated? ☐ Driver's seat ☐ Right front passenger seat ☐ Front middle passenger

☐ Rear right passenger ☐ Rear middle passenger ☐ Rear left passenger ☐ Other: _____

Who owns the car? _____ Year & Model of car: _____

15 What was the approximate damage done to the car you were in? $_____

Visibility at the time of accident: ☐ Poor ☐ Fair ☐ Good

Road conditions at time of accident: ☐ Icy ☐ Rainy & wet ☐ Clear ☐ Dark

Your car: ☐ Hit another car ☐ Was hit in the: ☐ Right ☐ Left ☐ Rear ☐ Front ☐ Side

Type of accident: ☐ Head-on collision ☐ Broadside collision ☐ Rear-end collision

☐ Front impact, rear-ended car in front ☐ Non-collision (explain) _____

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40 IMPACT / SEATBELT / HEADREST / SPEED

10 Describe in your own words what happened to you upon impact: _____

Were you prewarned that the accident was about to happen? ☐ Yes ☐ No

Did you brace for the impact? ☐ Yes ☐ No

Did you wear your seat belt / shoulder harness? ☐ Yes ☐ No

20 Does this car have headrests? ☐ Yes ☐ No

30 If yes, what was the position of those headrests compared to you 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? ☐ Yes ☐ No

36 If yes, did the airbag inflate? ☐ Yes ☐ No

37 If yes, were you injured by the inflated airbag? ☐ Yes ☐ No

38 If yes, what were the injuries? _____

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 moving? _____ mph (estimate)

70 How fast was the other car traveling? _____ mph (estimate)

HEAD & BODY POSITION / ABILITY TO MOVE

10 Head / Body position at the 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 impact, recall what parts of your **head** or **body** hit what part on the inside of your car: _____

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

☐ Shaken up but still 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? _____

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 Describe how you felt. *PLEASE BE SPECIFIC*

Immediately after the accident: _____

40 Later that ☐ Day ☐ Night: _____

50 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	☐ Nervousness
☐ Midback pain	☐ Ringing in the ear	☐ Tension	☐ Numb fingers	☐ Chest Pain
☐ Low back pain	☐ Loss of balance	☐ Shortness of breath	☐ Cold hands	☐ Cold sweats
☐ Sensitivity to light	☐ Loss of smell	☐ Irritability	☐ Cold feet	☐ Anxiety
☐ Pain behind eyes	☐ Loss of taste	☐ Depression	☐ Diarrhea	

70 WORK STATUS HISTORY

10 Occupation: _____ Employer: _____

20 Have you missed time from work? ☐ Yes ☐ No

30-40 If yes, How many hours of full-time employment missed: _____

50 If yes, Part-time hours missed: _____

60 ☐ Have been unable to work since the date of accident.

80 FIRST DOCTOR / HOSPITAL / CLINIC SEEN

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

15 If yes, who did you first get treatment from? _____

Date of first visit: _____ Doctor name: _____

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

30 Were you given treatment or medication? ☐ Yes ☐ No

40 If yes, what treatment was given? _____

What benefits did you receive from the treatment? _____

50 Date of last treatment? _____

90 SECOND DOCTOR / CLINIC SEEN

10 Second doctor or clinic seen: _____ Date of first visit: _____

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

20 Were you given treatment or medication? ☐ Yes ☐ No

30 If yes, what treatment was given? _____

What benefits did you receive from the treatment? _____

40 Date of last treatment? _____

100 THIRD DOCTOR / CLINIC SEEN

10 Third doctor or clinic seen: _____ Date of first visit: _____

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

20 Were you given treatment or medication? ☐ Yes ☐ No

30 If yes, what treatment was given? _____

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? ☐ No

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

_____

120 ACTIVITIES OF DAILY LIVING

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

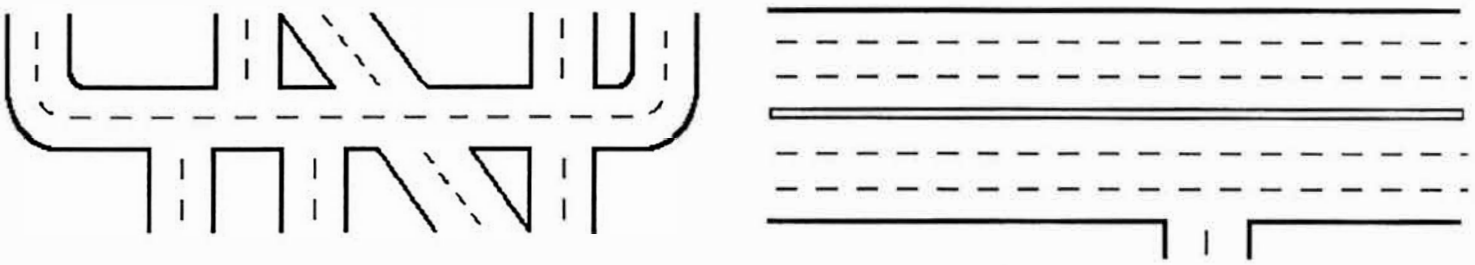
20 If yes, list them as:

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 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)

Insurance Name: _____ Policy #: _____ Claim #: _____

Address: _____ City: _____ ST: ___ Zip: _____

Adjuster's Name: _____ Phone: _____

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

Insured's Name: _____ Phone: _____

Insurance Name: _____ Policy #: _____ Claim #: _____

Address: _____ City: _____ ST: ___ Zip: _____

Adjuster's Name: _____ Phone: _____

Other Driver's Insurance Information - (Other car's driver - if another car was involved)

Other Drover's Name: _____ Phone: _____

Insurance Name: _____ Policy #: _____ Claim #: _____

Address: _____ City: _____ ST: _____ Zip: _____

Adjuster's Name: _____ Phone: _____

WRITE LEGIBLY

SUBJECTIVE COMPLAINTS

WRITE LEGIBLY

10 Explain **WHEN** and **HOW** it happened:_____

20 COMPLAINTS/SYMPTOMS: ☐ Come and go ☐ Came on gradually ☐ Came on suddenly

30 Symptoms have persisted for: ☐ Hours ☐ 1 Day ☐ Days ☐ Weeks ☐ Months ☐ Years

40 Symptoms developed from: ☐ A work-related injury ☐ An auto accident ☐ Neither a work or auto accident

50 PRESENT COMPLAINTS--**PLEASE BE SPECIFIC:**_____

_____

60 **PAIN LEVEL**: On a scale of 0–10, with 0 being you're pain free and can function quite well, and 10 being you're in excruciating pain all the time, where would you rate the intensity of your pain?

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

0 1 2 3 4 5 6 7 8 9 10

NO PAIN — LOW PAIN — MODERATE PAIN — INTENSE PAIN — EXCRUCIATING PAIN

70 What makes your condition worse? ☐ Nothing ☐ Lifting ☐ Trying to stand ☐ Standing ☐ Walking ☐ Sitting ☐ Movement ☐ Exercise ☐ Inactivity ☐ Work activities ☐ Home activities ☐ _____ Other

80 What makes your condition better? ☐ Nothing ☐ Standing ☐ Walking ☐ Sitting ☐ Movement ☐ Exercise ☐ Inactivity ☐ Lying down ☐ Sleep ☐ Hot shower/bath ☐ Stretching ☐ _____ Other

90 Have you ever had this condition/problem before? ☐ No

100 If yes, when?_____

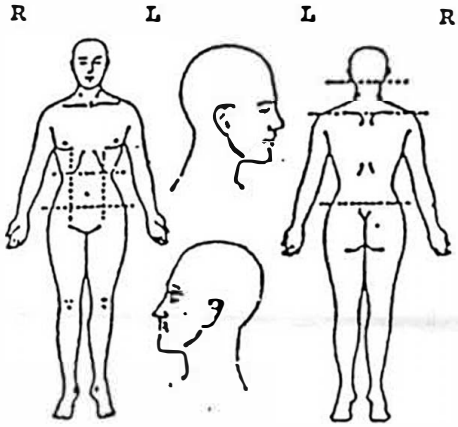
110 Give name(s) of doctor(s) previously seen for this present condition_____

120 What medications are you presently taking?_____

130– ABILITY TO PERFORM THE FOLLOWING ACTIVITIES:
160 *CODES:* **U=Unable/130 P=Painful/140 D=Difficult/150 L=Limited/150 N=Normal/160**

- ☐ Coughing or sneezing
- ☐ Getting in or out of a car
- ☐ Bending over forward
- ☐ Putting on clothes
- ☐ Putting on shoes
- ☐ Turning over in bed
- ☐ Getting out of bed
- ☐ Standing for more than 10 minutes
- ☐ Standing for more than 60 minutes
- ☐ Walking short distances
- ☐ Lying flat on stomach
- ☐ Lying on side with knees bent
- ☐ Climbing
- ☐ Kneeling
- ☐ Balancing
- ☐ Sitting
- ☐ Looking back
- ☐ Sleeping
- ☐ Stooping
- ☐ Gripping
- ☐ Pushing
- ☐ Pulling
- ☐ Reaching
- ☐ Sexual Activity

230 SHADE AND CODE AREA(S) OF COMPLAINT:
USE CODES: **P=Pain N=Numb S=Spasm**



170 CHECK YOUR NERVOUS SYSTEM COMPLAINTS

- ☐ Blurring vision
- ☐ Buzzing or ringing in ears
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression or crying spells
- ☐ Dizziness
- ☐ Fainting
- ☐ Paralysis
- ☐ Headaches
- ☐ How often do you have headaches?_____
- ☐ Loss of sleep
- ☐ Low resistance
- ☐ Muscle jerking
- ☐ Numbness

240 *(WOMEN ONLY) Are you pregnant?*
Date of onset of last menstrual cycle_____

250 Give date of last X-rays:_____

What body parts were they taken of?_____

180 Symptoms are **BETTER** in: ☐ AM ☐ Midday ☐ PM

190 Symptoms are **WORSE** in: ☐ AM ☐ Midday ☐ PM

200 Symptoms do not change with time of day ☐

Signature_____ Date _____

210– FAMILY HISTORY: *(heart/lung/back/neck problems)*
220 Father: Brother(s):
Mother: Sister(s):