WRITE LEGIBLY

PERSONAL INJURY PATIENT HISTORY

WRITE LEGIBLY

Name_____ Date_____ File#_____

30 HISTORY OF OCCURENCE

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: _____

40 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? ☐ 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

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? _____

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? ☐ 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 SEEN:_____ 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? _____

What benefits did you receive from the treatment? _____

40 Date of last treatment: _____

100 THIRD DOCTOR CLINIC SEEN

10 DOCTOR 3/CLINIC SEEN:_____ 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? _____

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?** ☐ 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 activities of your **home** daily routines that are different **now** than from **before** the accident? ☐ No

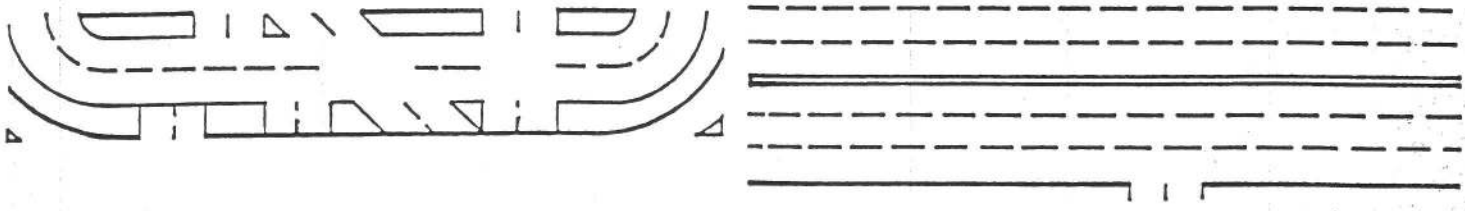
20 If yes, list them as:

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 THESE DIAGRAMS HOW THE ACCIDENT HAPPENED



ATTORNEY ON CASE

Do you have an attorney on this case? ☐ No

If yes, who? Name_____

Address_____ City_____ State_____ Zip_____

Patient Signature:_____ **Date**_____

AUTOMOBILE ACCIDENT — INSURANCE DATA

Patient's Insurance Company Information

Company Name:_____ PH:_____ Policy #:_____

P.O. Box/Street Number: _____ Adjuster's Name: _____

City/State/Zip:_____

Insured's Insurance Information

Insured's name if other than patient:_____ PH:_____

Company Name:_____ PH:_____ Policy #:_____

P.O. Box/Street Number: _____ Adjuster's Name: _____

City/State/Zip:_____

Other Driver's Insurance Information

Other Driver's Name (if another car was involved):_____ PH:_____

Company Name:_____ PH:_____ Policy #:_____

P.O. Box/Street Number: _____ Adjuster's Name: _____