PERSONAL INJURY HISTORY FORM

Name: _____ Phone#: (H) _____

(cell)_____

(W) _____

Home address: _____

Male ___ Female ___ Single ___ Married ___

Date of birth: _____ Age: _____ Social security #: _____

IN CASE OF EMERGENCY NOTIFY: _____

Name / phone number / relationship

PAST MEDICAL HISTORY

Please list any prior surgeries: (dates and residual complaints associated with surgeries)

_____

_____

_____

_____

Fractures: (list location / dates and residual complaints)

_____

_____

_____

Serious illness: (describe / dates and residual complaints)

_____

_____

_____

Work related injuries: (describe / dates and residual complaints)

_____

_____

_____

_____

Previous personal injuries: (auto, slip/fall, etc: describe/ dates and residual complaints)

_____

_____

_____

_____

Name: _____

Sports injuries: (describe/dates and residual complaints)

_____

_____

_____

Do you have any previous history of complaints similar to those you have currently?

_____

_____

_____

Any prior treatment by a physician (DC/DO/MD) for these complaints?

No ___ Yes ___: what kind of treatment and for how long? _____

_____

_____

CURRENT MEDICAL HISTORY

Current health problems: none ____ or list below.

_____

_____

_____

Current medications taken: none ___ or list below

Medication	condition	dosage

_____

_____

_____

_____

_____

_____

_____

ACCIDENT HISTORY

Date of accident: _____ Time of accident:_____ am/pm

Was the accident on the job? Yes ___ No ___

Was this a motor vehicle accident? Yes ___ No ___ ; other: _____

If a motor vehicle accident, were you the:

___ Driver ___ Front seat passenger (center/right) ___ Rear seat passenger (right/center/left)

___ Motorcycle operator ___ Motorcycle passenger ___ Other: _____

If you were the passenger, the vehicle was driven by: _____

The vehicle you were in was (year/make/model): _____

The other vehicle (year/make/model): _____

The weather at the time of the accident was: ___ clear ___ rainy ___ foggy ___ snowing ___ sleat

The road conditions were: ___ dry ___ damp ___ wet ___ snow ___ icy

Head restraints in your vehicle:

___ none ___ integrated into seat ___ adjustable: what position were they in?

___ up position ___ down position ___ middle ___ can't remember

If head restraints were adjustable, was the position altered by the accident?

___ no ___ yes: how? _____

Was the seat broken? ___ no ___ yes Did the airbag deploy? ___ no ___ yes

Did you receive any injuries from the air bag?

___ no ___ yes (explain): _____

Were you wearing a seat belt? ___ lap belt ___ shoulder harness ___ don't know

Did you receive any injuries from the seat belt/harness? _____

Body position at the time of the accident: ___ leaning forward ___ twisted/turned R / L

Head position at the time of the accident: ___ forward, turned ___ left ___ right, ___ up ___ down

Hand position: ___ one on wheel ___ two on wheel ___ other: _____

Were the brakes applied? ___ no ___ yes ___ don't know

PLEASE DESCRIBE THE ACCIDENT IN YOUR BEST WORDS:

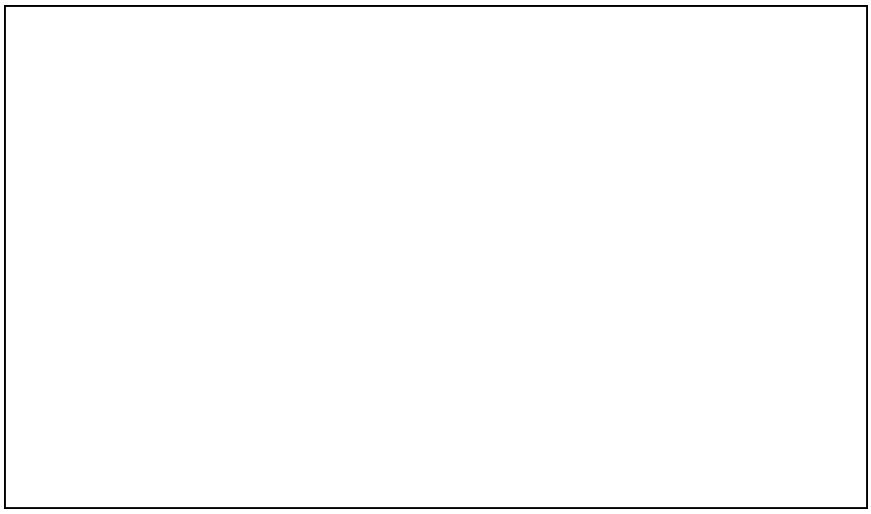
_____

_____

_____

_____

Please diagram the accident below, labeling the streets or freeways, and directions



Were you aware of the impending crash? ___ no ___ yes Did you hear skidding/braking? ___ no ___ yes

If yes, how did you brace yourself? _____

<u>During the crash</u>:

Did the your vehicle strike any other objects after the crash? ___ no ___ yes: describe -

_____

_____

Where you wearing a hat or glasses? ___ no ___ yes: were they knocked off? ___ no ___ yes

Did any part of your body strike any object inside the car? _____

_____

Did you loose consciousness? ___ no ___ yes: for how long? _____

What was the estimated property damage to your car? ___ mild ___ moderate ___ major

Estimated repair cost? $_____

Were the police called to the scene? ___ no ___ yes: was a police report taken? ___ no ___ yes

<u>After the crash</u>:

Did you experience any of the following symptoms? ___ headache ___ dizziness ___ confusion

___ dazed feeling ___ nausea ___ neck pain ___ numbness

___ extremity pain: where? _____

___ back pain: where? _____

___ other? _____

_____

When did you symptoms first appear?

___ immediately: describe which -_____

___ hours later: describe which - _____

Name:

Where did you go immediately after the accident? ___ home ___ work ___ other residence

___ private doctor (name): _____

___ Emergency Room/Hospital (name): _____

How? Ambulance: ___ no ___ yes, other: _____

Emergency Department:

Were radiographs (x-rays) taken? ___ no ___ yes MRI: ___ no ___ yes Cat Scan: ___ no ___ yes

Body parts imaged - _____

_____

Treatment at ER/Hospital: _____

_____

Follow-up instructions: _____

Treatment History:

1. Doctor's name: _____ Specialty: _____

Date first seen: _____ Treatment received / frequency: _____

_____

Are you currently treating with this doctor? ___ no ___ yes Is the treatment helping? ___ no ___ yes

Please mark the areas on your body (right) where you are having pain.