

WRITE LEGIBLY

PERSONAL INJURY PATIENT HISTORY

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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:

- | | | | | |
|--|---|--|--|---------------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Neck pain/stiffness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Midback pain | <input type="checkbox"/> Ringing/buzzing ears | <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in 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 | <input type="checkbox"/> 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

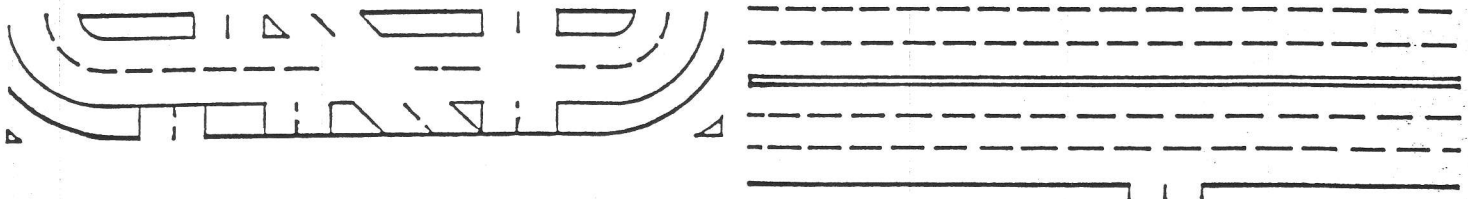
20 If yes, list them as:

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 DIAGRAMMS 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: _____