PERSONAL INJURY PATIENT HISTORY

30 HISTORY OF OCCURRENCE

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
□ Reen-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? 
   □ Yes □ No
   If yes, what bruises did you get from this accident? 
   □ Yes □ No
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
   □ Neck pain/stiffness □ Fainting □ Fatigue □ Constipation
   □ Midback pain □ Ringing/buzzing ears □ Tension □ Chest pain
   □ Low back pain □ Loss of balance □ Shortness of breath □ Nervousness
   □ Eyes sensitive to light □ Loss of smell □ Irritability □ Cold hands
   □ Pain behind eyes □ Loss of taste □ Depression □ Cold feet
   □ Cold hands □ Headache □ Depression □ Constipation
   □ Dizziness □ Loss of memory □ Sleeping problems
   □ Fatigue □ Chest pain □ Fainting □ Headache
   □ Ringing/buzzing ears □ Tension □ Loss of memory
   □ Shortness of breath □ Fatigue □ Fainting
   □ Irritability □ Chest pain □ Headache
60 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 □ No Were X-rays taken? □ Yes □ No □ No
30 Were you given treatment? □ No □ No □ 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 □ No Were X-rays taken? □ Yes □ No □ No
20 Were you given treatment? □ No □ No □ 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 □ No Were X-rays taken? □ Yes □ No □ No
20 Were you given treatment? □ No □ No □ 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

ATTOOON 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: ___________________________

P.O. Box/Street Number: __________________________

City/State/Zip: ________________________________

Insured's Insurance Information
Insured's name if other than patient: ________________________________  PH: ___________________________

Company Name: ________________________________  PH: ___________________________

P.O. Box/Street Number: __________________________

City/State/Zip: ________________________________

Other Driver's Insurance Information
Other Driver's Name (if another car was involved): ________________________________  PH: ___________________________

Company Name: ________________________________  PH: ___________________________

P.O. Box/Street Number: __________________________

Adjuster's Name: ________________________________