Personal Injury History

Guest's Name: _____ Today's Date:_____

Accident Details

-Date of accident: _____ - Time of day: _____

-Number of vehicles involved in crash: _____ - Number of people in YOUR vehicle: _____

-Estimated cost of damage to YOUR vehicle: _____ - Totaled? ▫ Yes ▫ No

- Were the police notified: ▫ Yes ▫ No - Was a Report made? ▫ Yes ▫ No

-Location accident occurred and direction you were traveling in at time of accident: North South East West

Street: _____ City: _____ State: _____

-Were you struck by another vehicle or did you run into someone else? (Please explain how collision occurred)_____

_____

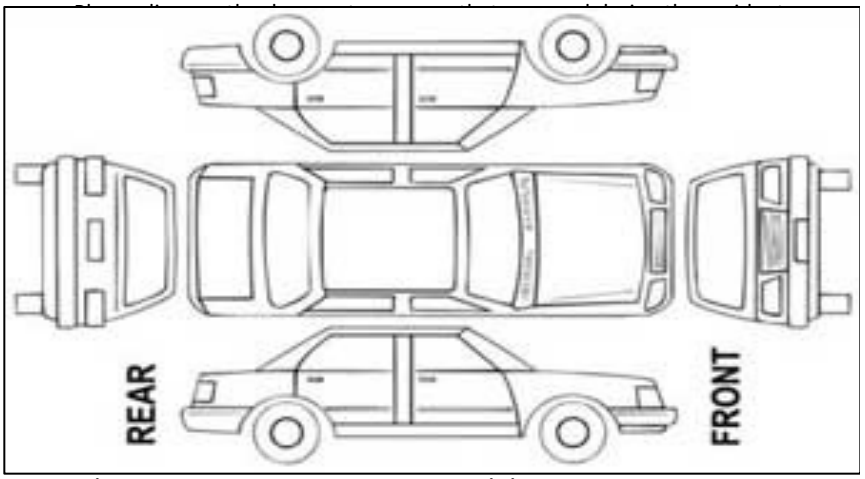
_____

_____

_____

_____

_____



-What kind of car were you driving? Year: _____Make:_____Model:_____

-What kind of car was the other vehicle? Year: _____Make:_____Model:_____

-Was your vehicle…? Speeding up (_____~mph) Slowing down (_____~mph) Stopped

-Was the other vehicle…? Speeding up (_____~mph) Slowing down (_____~mph) Stopped

-How did your vehicle move during the crash? (Kept going straight, rolled over, spun around, etc) _____

_____

-Were you aware of the oncoming collision? ▫ Yes ▫ No

-Where were you seated in the car (driver, front passenger etc.)? _____

-Were you wearing a safety belt? ▫ Yes ▫ No If "yes" what kind? ▫Lap belt ▫Shoulder strap ▫Both

- Did you sustain any injuries/bruises from the safety belt? (Explain):_____

-Did you have a headrest? ▫ Yes ▫ No If "yes" what was the height/positioning at the time of the accident?

▫Higher than head ▫Middle ▫Lower than head AND ▫Touching head ▫Not touching head

Your body during the accident

-What position was your head during the accident? (Looking left, tilted right, etc.) _____

-What position was your torso during the accident? (Turned right, bent forward, etc.) _____

-What position were your hands during the accident? (In lap, on wheel, etc.) _____

-Did any part of your body strike any part of the car? (Explain)_____

_____

- Loss of consciousness? ▫ Yes ▫ No if "yes", please explain: _____

- Were you stunned? ▫ Yes ▫ No If "yes", how long? _____

- Did you feel any pain? ▫ Yes ▫ No if "yes" where?_____

How long after the accident? _____

- Did you find bruises? ▫ Yes ▫ No if "yes", where? _____

- List the extent of your injuries as you know them: _____

_____

- Have you previous been involved in any accidents? ▫ Yes ▫ No if "yes", list date/type of accident/injuries etc._____

_____

- Did you have any physical complaints BEFORE this accident? ▫ Yes ▫ No if "yes", please explain_____

_____

Check any symptoms that you have noticed since the accident (circle any that you are currently experiencing)

▫Headache	▫Low back pain	▫Face flushed	▫Constipation
▫Skull or head pain	▫Low back stiffness	▫Loss of color	▫Diarrhea
▫Neck pain	▫Hip pain	▫Dizziness	▫Excessive perspiration
▫Neck stiffness	▫Buttock pain	▫Fainting	▫Loss of perspiration
▫Head feels too heavy	▫Leg pain	▫Sinus trouble	▫Loss of taste
▫Shoulder pain	▫Leg numbness	▫Loss of smell	▫Cold sweats
▫Shoulder stiffness	▫Pins and needles in legs	▫Eye stain	▫Fever
▫Arm pain	▫Numbness in feet/toes	▫Difficulty focusing	▫Swelling, where: _____
▫Arm Numbness	▫Cold feet	▫Pain behind eyes	▫Pain while riding in car
▫Pins and needles in arms	▫Depression	▫Eyes sensitive to light	▫Pain/difficulty bending
▫Numbness in hands/fingers	▫Anxiety	▫Double Vision	▫ Pain/difficulty standing
▫Cold hands	▫Tension	▫Buzzing or ringing in ears	▫ Pain/difficulty sitting
▫Upper back pain	▫Irritability	▫Loss of balance	▫ Pain/difficulty walking
▫Mid back pain	▫Nervousness	▫Palpitations	▫ Pain/difficulty lifting
▫Painful breathing	▫Mental dullness	▫Shortness of breath	▫Pain while twist/turning
▫Chest pain	▫Loss of memory	▫Digestive problems	▫Difficulty rising to walk
▫Rib pain	▫Difficulty sleeping	▫Nausea	▫Pain doing occupation
▫Fatigue	▫Tremors	▫Vomiting	▫Other _____

-Did you require post-accident care or hospitalization? ▫ Yes ▫ No if "yes", where and how did you get there?_____

_____

- Were you examined? ▫ Yes ▫ No if "yes" by whom? _____

- Were X-rays taken? ▫ Yes ▫ No if "yes" of what body parts? _____

- What is your occupation? _____Job duties? _____

_____ _____

Patient's or Legal Guardian's Signature Date

- Have you missed work as a result of this accident? ▫ Yes ▫ No If "yes" how many days? _____

- Do you have any congenital (from birth) factors t relate to this/these problems? ▫ Yes ▫ No if "yes" please describe.