

**PERSONAL INJURY HISTORY**

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ ACC# \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_

1. Date of accident: \_\_\_\_\_ Time of Day: \_\_\_\_\_ AM/PM
2. Number of people in your vehicle? \_\_\_\_\_ Were you wearing seat belts? \_\_ Yes \_\_ No.
3. Were you the : \_\_ Driver \_\_ Passenger in the \_\_ Front seat \_\_ back seat.
4. The cost or type of damage to your vehicle? \_\_\_\_\_
5. At impact I felt a \_\_ jolt \_\_ sudden impact \_\_ powerful blow, throwing by body back and forth
6. Did your car move on impact \_\_ Yes \_\_ No How far? \_\_\_\_\_
7. Did your car hit anything else on impact \_\_ Yes \_\_ No Describe: \_\_\_\_\_  
\_\_\_\_\_
8. Did your seat dislodge on impact \_\_ Yes \_\_ No
9. Were you struck from: \_\_ behind \_\_ front \_\_ left side \_\_ Right side
10. The other vehicle was \_\_ in back \_\_ in front \_\_ on left \_\_ on right at the time of the collision
11. At the time of the collision, you were looking \_\_ to the right \_\_ to the left \_\_ forward \_\_ up  
\_\_ down \_\_ turning to the right \_\_ Turning to the left
12. Due to the impact, you were thrown \_\_ backward \_\_ forward \_\_ to the right \_\_ to the left
13. Did you strike your (ex: head)... name body part(s) \_\_\_\_\_ against the \_\_  
steering wheel \_\_ dashboard \_\_ other \_\_\_\_\_
14. Due to the impact, I had \_\_ cuts \_\_ bruising \_\_ dislocations (name area of the body)  
\_\_\_\_\_
15. You \_\_ were \_\_ were not able to get out and walk from the vehicle unaided
16. Were you knocked unconscious? \_\_ Yes \_\_ No If yes, for how long? \_\_\_\_\_
17. After the accident, you went \_\_ home \_\_ to the hospital \_\_ other \_\_\_\_\_  
You were taken by \_\_ self \_\_ another \_\_ ambulance \_\_ police vehicle
18. If you went to the hospital, what hospital? \_\_\_\_\_ dates there? \_\_\_\_\_  
While there, you were \_\_ examined \_\_ X-rayed \_\_ given medication \_\_ other \_\_\_\_\_
19. The night following the accident was \_\_ painful \_\_ restless \_\_ uneventful \_\_ other \_\_\_\_\_
20. The following day you felt \_\_ worse \_\_ the same \_\_ better

21. Have you missed work?  Yes  No If Yes, from (date) \_\_\_\_\_ to (date) \_\_\_\_\_

22. Your type of employment: \_\_\_\_\_

23. Were the police notified of the accident?  Yes  No

24. List doctor(s) seen for this accident: \_\_\_\_\_

\_\_\_\_\_

25. List your medication(s): \_\_\_\_\_

26. Please describe the accident in your own words: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

27. Check symptoms you have noticed since the accident:

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Headaches        | <input type="checkbox"/> Irritability         | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Buzzing in ears |
| <input type="checkbox"/> Neck pain        | <input type="checkbox"/> Chest pain           | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Neck stiff       | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Depression          | <input type="checkbox"/> Fainting        |
| <input type="checkbox"/> Sleeping problem | <input type="checkbox"/> Head seems heavy     | <input type="checkbox"/> Lights bother eyes  | <input type="checkbox"/> Loss of smell   |
| <input type="checkbox"/> Back pain        | <input type="checkbox"/> Pins/Needles in arms | <input type="checkbox"/> Loss of memory      | <input type="checkbox"/> Loss of taste   |
| <input type="checkbox"/> Nervousness      | <input type="checkbox"/> Numbness in fingers  | <input type="checkbox"/> Ears ring           | <input type="checkbox"/> Diarrhea        |
| <input type="checkbox"/> Tension          | <input type="checkbox"/> Muscle spasms        | <input type="checkbox"/> Nervous stomach     | <input type="checkbox"/> Cold sweats     |
| <input type="checkbox"/> Shoulder pain    | <input type="checkbox"/> Numbness in toes     | <input type="checkbox"/> Face Flushed        |  |

Did you have any physical complaints BEFORE THE ACCIDENT?  Yes  No If yes, please describe

\_\_\_\_\_

\_\_\_\_\_

Other Doctors seen for this condition:

Doctor's name \_\_\_\_\_ Diagnosis \_\_\_\_\_

Doctor's name \_\_\_\_\_ Diagnosis \_\_\_\_\_

Doctor's name \_\_\_\_\_ Diagnosis \_\_\_\_\_

Doctor's name \_\_\_\_\_ Diagnosis \_\_\_\_\_

Is there anything else about your health I should know? \_\_\_\_\_

\_\_\_\_\_