PERSONAL INJURY PATIENT HISTORY

NAME ______________________________ DATE ______________________

HISTORY

DATE OF ACCIDENT ___________ TIME _____________ AM PM WHO WAS DRIVING THE CAR? ______________________

WHAT SEAT WERE YOU SITTING IN? ______________________ YEAR AND MAKE OF CAR ______________________

IN YOUR OWN WORDS, DESCRIBE THE ACCIDENT ____

____

____

____

WERE YOU WEARING YOUR SEATBELTS ___ YES ___ NO DID YOU SEE THE ACCIDENT COMING ___ YES ___ NO

HEAD / BODY POSITION AT TIME OF IMPACT: [ ] HEAD TURNED: [ ] RIGHT [ ] LEFT [ ] LOOKING BACK [ ] LOOKING FORWARD [ ] OTHER ____

[ ] BODY IN STRAIGHT SITTING POSITION [ ] BODY ROTATED: [ ] RIGHT [ ] LEFT

AT THE TIME OF THE ACCIDENT, DO YOU RECALL IF YOU STRUCK ANYTHING INSIDE YOUR CAR. ______________________

____

AS A RESULT OF THE ACCIDENT, WERE YOU:

[ ] RENDERED UNCONSCIOUS; LENGTH OF TIME_______ [ ] DAZED WITH CIRCUMSTANCES VAGUE [ ] SHAKEN UP BUT COULD FUNCTION

DESCRIBE ANY CUTS OR BRUISES ____

____

DID YOU GO TO THE HOSPITAL AFTER THE ACCIDENT ___YES ___NO WHEN _____________ WHICH HOSPITAL ______________

HOW DID YOU GET TO THE HOSPITAL? [ ] AMBULANCE [ ] DROVE MYSELF [ ] SOMEONE ELSE DROVE ME WERE YOU EXAMINED ___YES ___NO

WERE X-RAYS TAKEN ___YES ___NO WERE YOU PRESCRIBED ANY MEDICATION ___ YES ___NO WHAT TYPE ______________

DID YOU SEEK ANY ADDITIONAL MEDICAL CARE AFTER THE ACCIDENT ___YES ___NO LIST NAME AF ANY DOCTORS ______________

DATE OF FIRST VISIT ____________ WERE X-RAYS TAKEN ___YES ___NO LIST ANY TYPE OF TREATMENT ______________

PAST HISTORY

DID YOU HAVE ANY PHYSICAL COMPLAINTS BEFORE THIS ACCIDENT ____YES ___NO IF YES PLEASE DESCRIBE ______________

____

HAVE YOU EVER HAD ANY PRIOR INJURIES, ACCIDENTS, DISEASES OR TREATMENT TO THE AREA OF YOUR BODY NOW AFFECTED ___YES ___NO

IF YES, PLEASE DESCRIBE: ____

____

PLEASE LIST ANY OPERATIONS YOU HAVE HAD ____

WORK STATUS

OCCUPATION: ______________________ EMPLOYER ______________________ HAVE YOU MISSED TIME FROM WORK ___YES ___NO

DATES OF LOSS ______________________ HAVE YOU RETURNED TO WORK ___YES ___NO PLEASE LIST ANY RESTRICTIONS YOU HAVE

BEEN PLACED ON: ____

WHAT ACTIVITIES, IF ANY, AGGRAVATE YOUR CONDITION WHILE AT WORK: ______________________

PATIENT SIGNATURE ______________________________ DATE ______________________

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