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 _____