# PERSONAL INJURY PATIENT HISTORY

**Last Name** _____ **First Name**_____ **Date** _____

**Insurance Company:**_____ **Claim Number:** _____

**Adjuster's Name:**_____ **Insurance Phone #:**_____

1. Date of Accident: _____ 2. Time:_____ AM/PM
2. Driver of Car: _____
3. Where were you seated? _____
4. Who owns the car? _____
5. Year & Model of your car. _____

   Year & Model of the **other car**: _____
6. What was the approximate damage done to your car? $_____
7. Visibility at time of accident: ☐ Poor ☐ Fair ☐ Good ☐ Other: _____
8. Road Conditions at time of accident: ☐ Icy ☐Rainy ☐Wet ☐Clear ☐Dark

   Other (describe): _____
9. Where was your car struck?

   In your own words, please describe the accident: _____

   _____

   _____
10. Type of Accident: ☐Head-on Collision ☐Broad-side Collision ☐Front Impact

    ☐Rear-end car in front ☐Rear Impact ☐Non- collision
11. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car: _____
12. Did you see the accident coming? ☐ Yes ☐ No
13. Did you brace for impact? ☐ Yes ☐ No
14. Were seatbelts worn? ☐ Yes ☐ No
15. Were shoulder harnesses worn? ☐ Yes ☐ No
16. Does your car have headrests? ☐ Yes ☐ No
17. 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
18. Was your car braking? ☐ Yes ☐ No
19. Was your car moving at the time of the accident? ☐ Yes ☐ No

20. If yes, how fast would you estimate you were going? _____ mph

21. How fast would you estimate the other car was going? _____ mph

22. Head/ Body position at the time of impact:

☐ Head turned left/right ☐ Body straight in sitting position

☐ Head looking back ☐ Body rotated right/left

☐ Head straight forward ☐ Other:_____

23. As a result of the accident you were: ☐ Rendered unconscious ☐ In shock

☐ Dazed, circumstances vague ☐ Other: _____

24. How was the shoulder harness adjusted? ☐Loose ☐ Snug

25. Were you wearing a hat or glasses? ☐ Yes ☐ No

26. Could you move all parts of your body? ☐ Yes ☐ No

27. If no, what parts couldn't you move and why?

_____

28. Were you able to get out of the car and walk unaided? ☐ Yes ☐ No

29. If no, why not? _____

30. Did you get any bleeding cuts? ☐ Yes ☐ No If yes, where? _____

31. Did you get any bruises? ☐ Yes ☐ No If yes, where? _____

32. Please describe how you felt:

Immediately after the accident: _____

Later that day: _____

The **next** day: _____

33. Check symptoms apparent since the accident:

| | | |
|---|---|---|
| ☐ Headache | ☐ Neck pain/ Stiffness | ☐ Mid back pain |
| ☐ Eyes Light Sensitive | ☐ Pain Behind Eyes | ☐ Dizziness |
| ☐ Fainting | ☐ Sleeping problems | ☐ Numbness in Fingers |

***(continued on next page)***

| | | |
|---|---|---|
| ☐ Numbness in toes | ☐ Loss of smell | ☐ Loss of taste |
| ☐ Loss of memory | ☐ Fatigue | ☐ Breath shortness |
| ☐ Irritability | ☐ Depression | ☐Ringing/ Buzzing |
| ☐ Loss of Balance | ☐ Tension | ☐ Cold hands |
| ☐ Cold feet | ☐ Diarrhea | ☐ constipation |
| ☐ Chest pain | ☐ Nervousness | ☐ Cold Sweats |
| ☐ Anxious | ☐ Facial pain | ☐ Clicking or popping jaw |
| ☐ Low back pain | ☐ Other: _____ | |

34. Occupation: _____

35. Employer: _____

36. Have you missed **any** time from work: ☐ Yes ☐ No

37. If yes, full time off work: _____ to _____

38. If yes, part time off work: _____ to _____

39. Did you seek **any** medical help immediately after the accident? ☐ Yes ☐ No

40. If yes, how did you get there? ☐ Ambulance ☐ Police

☐ Someone else drove me ☐ Drove own car ☐ Other: _____

41. Doctor #1 / Hospital Name: _____

42. First Visit Date: _____

43. Were you examined? ☐ Yes ☐ No **Admitted?** ☐ Yes ☐ No

44. Were X-rays taken? ☐ Yes ☐ No **Other tests:** _____

45. Did you receive treatment? ☐ Yes ☐ No ☐ Medications ☐ Braces ☐ Collars

46. If yes, what kind of treatment did you receive? _____

47. What benefits did you receive from the treatment? _____

48. Date of last treatment: _____

49. Doctor #2 / Office Name: _____

50. First Visit Date: _____

51. Were you examined? ☐ Yes ☐ No

52. Were X-rays taken? ☐ Yes ☐ No

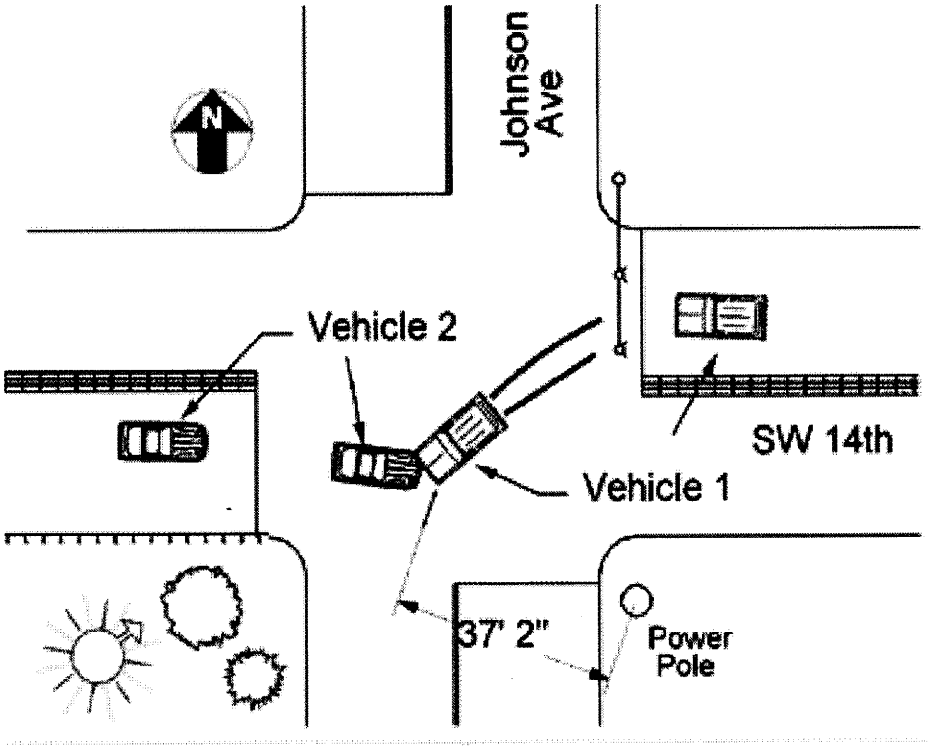
53. Did you receive treatment? ☐ Yes ☐ No

54. If yes, what kind of treatment did you receive? _____

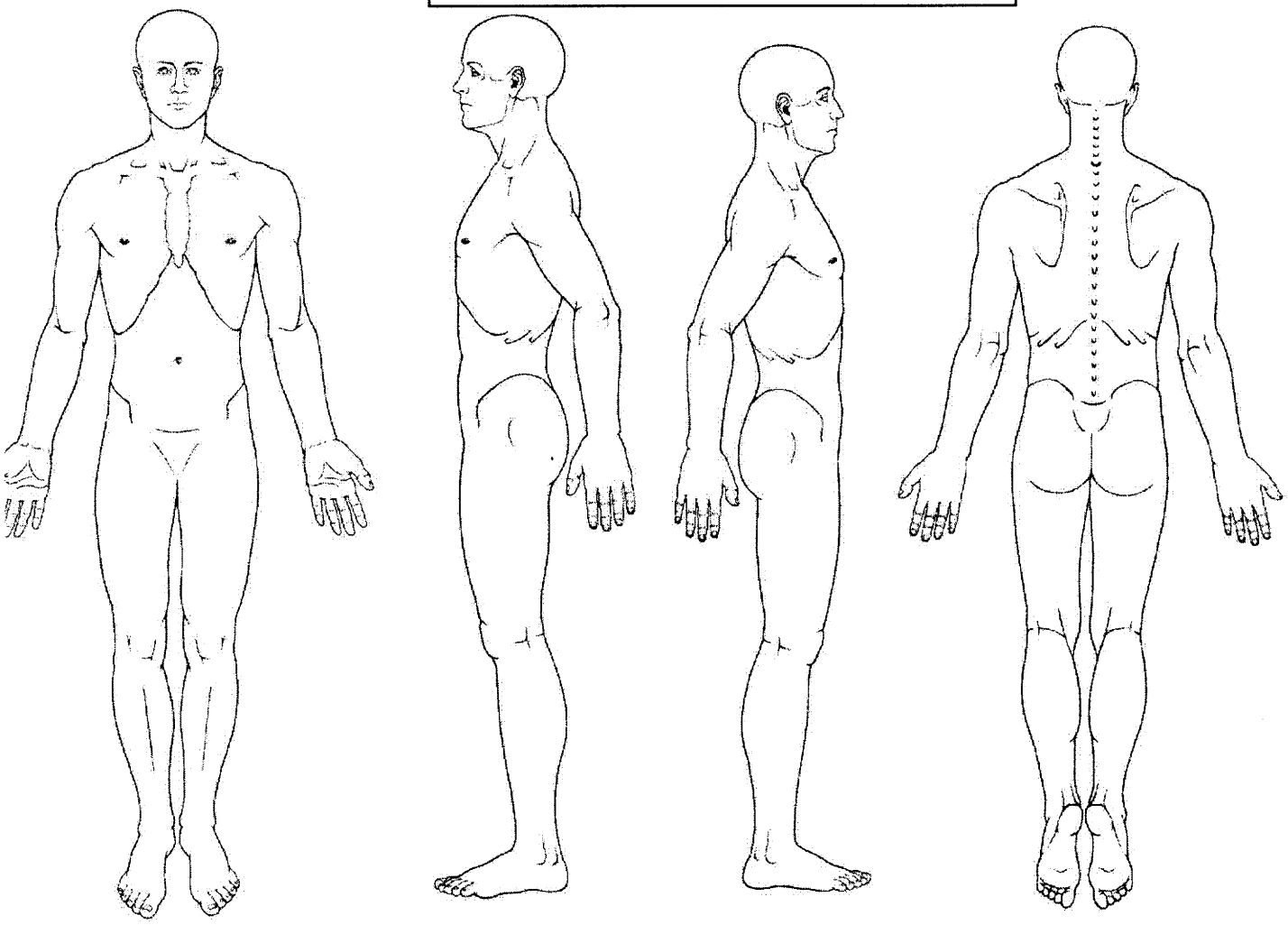
**Please diagram the accident below.** **When you do please remember to draw in all streets, traffic lights and traffic signs. If you can label the names of the roads or pertinent landmarks. Please label which car is yours, and if there were other cars that had to avoid the accident or caused the accident please diagram those as well. Make sure it is easy to identify the direction your car was traveling at the time of the accident with motion arrows.**

**(See an excellent and detailed diagram at the bottom of the page.)**

# Example:



# PAIN LOCATION



Please mark off *ALL the current areas* of your complaint(s) on the diagrams above. Please use the following symbols on the pain diagram to accurately describe your condition.

| | |
|---|---|
| **PPP** | **Where you experience Pain** |
| **NNN** | **Where you experience Numbness** |
| **TTT** | **Where you experience Tingling** |
| **BBB** | **Where you experience Burning** |
| **CCC** | **Where you experience Cramping** |

**Please place an "X" on the line below relating to where you condition exists today.**

***NO*** Pain/Numb/etc. Pain/Numb/Tingle
All Activities OK |----------| Activity Difficulty
**Best Ever Felt** **Worst Ever Felt**

***Office use only: VAS=____***

***PATIENT SIGNITURE_____ DATE_____***