WRITE LEGIBLY

PERSONAL INJURY PATIENT HISTORY

WRITE LEGIBLY

Patient Name: ____ Date: ________________

30 HISTORY OF OCCURRENCE

10 Date of Accident: ________________ Time: ___:___ ☐ am ☐ pm Driver of car: ____________________

Where were you seated? ☐ Driver's seat ☐ Right front passenger seat ☐ Front middle passenger

○ Rear right passenger ☐ Rear middle passenger ☐ Rear left passenger ☐ Other: ____________

Who owns the car? ________________________ Year & Model of car: __________________________

15 What was the approximate damage done to the car you were in? $______________________________

Visibility at the time of accident: ☐ Poor ☐ Fair ☐ Good

Road conditions at time of accident: ☐ Icy ☐ Rainy & wet ☐ Clear ☐ Dark

Your car: ☐ Hit another car ☐ Was hit in the: ☐ Right ☐ Left ☐ Rear ☐ Front ☐ Side

Type of accident: ☐ Head-on collision ☐ Broadside collision ☐ Rear-end collision

☐ Front impact, rear-ended car in front ☐ Non-collision (explain) __________________

____

40 IMPACT / SEATBELT / HEADREST / SPEED

10 Describe in your own words what happened <u>to you</u> upon impact: ______________________________

____

Were you prewarned that the accident was about to happen? ☐ Yes ☐ No

Did you brace for the impact? ☐ Yes ☐ No

Did you wear your seat belt / shoulder harness? ☐ Yes ☐ No

20 Does this car have headrests? ☐ Yes ☐ No

30 If <u>yes</u>, what was the position of those headrests compared to you head before the accident?

☐ Top of headrest even with **bottom** of the head ☐ Top of headrest even with **top** of the head

☐ Top of headrest even with **middle** of the neck

35 Was the car equipped with an airbag where you were seated? ☐ Yes ☐ No

36 If <u>yes</u>, did the airbag inflate? ☐ Yes ☐ No

37 If <u>yes</u>, were you injured by the inflated airbag? ☐ Yes ☐ No

38 If <u>yes</u>, what were the injuries? ____

40 Was your car braking? ☐ Yes ☐ No

50 Was your car moving at the time of accident? ☐ Yes ☐ No

60 If <u>yes</u>, how fast would you estimate you were moving? ____________ mph (estimate)

70 How fast was the other car traveling? ____________ mph (estimate)

HEAD & BODY POSITION / ABILITY TO MOVE

10 Head / Body position at the time of impact: ☐ Head turned: ☐ Right ☐ Left ☐ Head looking back

☐ Head straight forward ☐ Body straight in sitting position ☐ Body rotated: ☐ Right ☐ Left

20 At the time of impact, recall what parts of your **head** or **body** hit what part on the inside of your car: ____________

____

____

30 As a result of the accident were you: ☐ Rendered unconscious ☐ Dazed, circumstances vague

☐ Shaken up but still could function

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

50 If <u>no</u>, what body parts could you not move and why? ______________________________

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

70 If <u>no</u>, why couldn't you get out of the car and walk unaided? ______________________

80 Did you receive any medical assistance at the scene of the accident? ☐ Yes ☐ No

60 SYMPTOMS FROM ACCIDENT

10 Did you get any bleeding cuts or bruises? ☐ No

20 If yes, what **bleeding cuts** did you get from this accident? ______________________

If yes, what **bruises** did you get from this accident? ______________________

30 Describe how you felt. *PLEASE BE SPECIFIC*

Immediately after the accident: ______________________

40 Later that ☐ Day ☐ Night: ______________________

50 The next days: ______________________

60 Check symptoms apparent **since** the accident:

☐ Headache	☐ Dizziness	☐ Loss of memory	☐ Sleeping problems	☐ Constipation
☐ Neck pain/stiffness	☐ Fainting	☐ Fatigue	☐ Numb toes	☐ Nervousness
☐ Midback pain	☐ Ringing in the ear	☐ Tension	☐ Numb fingers	☐ Chest Pain
☐ Low back pain	☐ Loss of balance	☐ Shortness of breath	☐ Cold hands	☐ Cold sweats
☐ Sensitivity to light	☐ Loss of smell	☐ Irritability	☐ Cold feet	☐ Anxiety
☐ Pain behind eyes	☐ Loss of taste	☐ Depression	☐ Diarrhea	

70 WORK STATUS HISTORY

10 Occupation: ______________________ Employer: ______________________

20 Have you missed time from work? ☐ Yes ☐ No

30-40 If yes, How many hours of full-time employment missed: ____________

50 If yes, Part-time hours missed: ____________

60 ∟ Have been unable to work since the date of accident.

80 FIRST DOCTOR / HOSPITAL / CLINIC SEEN

10 Did you go to seek medical help immediately or soon after the accident? ∟ No

15 If yes, who did you first get treatment from? ______________________

Date of first visit: ____________ Doctor name: ______________________

20 Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

30 Were you given treatment or medication? ☐ Yes ☐ No

40 If yes, what treatment was given? ______________________

What benefits did you receive from the treatment? ______________________

50 Date of last treatment? ____________

90 SECOND DOCTOR / CLINIC SEEN

10 Second doctor or clinic seen: ______________________ Date of first visit: ____________

Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

20 Were you given treatment or medication? ☐ Yes ☐ No

30 If yes, what treatment was given? ______________________

What benefits did you receive from the treatment? ______________________

40 Date of last treatment? ____________

100 THIRD DOCTOR / CLINIC SEEN

10 Third doctor or clinic seen: ______________________ Date of first visit: ____________

Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

20 Were you given treatment or medication? ☐ Yes ☐ No

30 If yes, what treatment was given? ______________________

What benefits did you receive from the treatment? ______________________

40 Date of last treatment? ____________

110 PRIOR SIMILAR SYMPTOMS

10 Did you have any physical complaints just before the accident? ☐ Yes ☐ No

20 If yes what physical symptoms did you have **just before the accident?** ____________________

30 **PRIOR** to this accident, have you **EVER** had symptoms similar to what you're experiencing now? ☐ No

40 If **yes**, please explain (briefly include past falls, injuries, accidents, operations, etc.): ____________________

120 ACTIVITIES OF DAILY LIVING

10 Do you notice any of you home activities that are different now than **before** the accident? ☐ Yes ☐ No

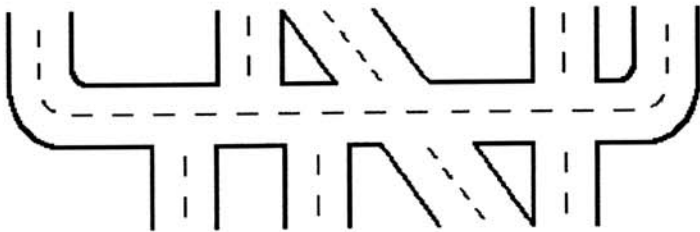
20 If yes, list them as:

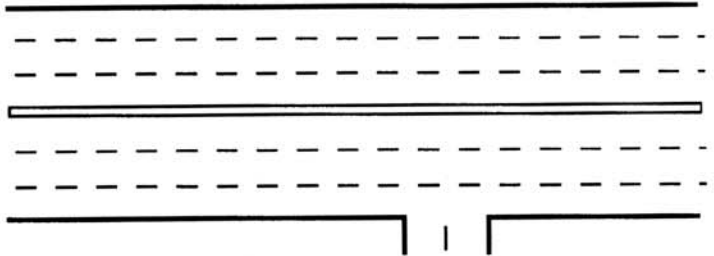
30 Those activities that you are **now unable** to do are (be specific): ____________________

40 Those activities that are **now painful** to do are (be specific): ____________________

50 Those activities that are **now difficult** to do are (be specific): ____________________

INDICATE ON THIS DIAGRAM HOW THE ACCIDENT HAPPENED - (NOTE THE CAR YOU WERE IN AS CAR "A")





ATTORNEY ON CASE

Do you have an attorney on this case? ☐ No

If yes, who? Name: ____________________ Phone: ____________

Address: ____________________ City: ____________ State: ______ Zip: ____________

Patient Signature: ____________________ Date: ____________

AUTOMOBILE ACCIDENT - INSURANCE DATA

Patient's Insurance Company Information - (You)

Insurance Name: ____________________ Policy #: ____________ Claim #: ____________

Address: ____________________ City: ____________ ST: ______ Zip: ____________

Adjuster's Name: ____________________ Phone: ____________

Insured's Insurance Information - (Driver of car you were in - if not you)

Insured's Name: ____________________ Phone: ____________

Insurance Name: ____________________ Policy #: ____________ Claim #: ____________

Address: ____________________ City: ____________ ST: ______ Zip: ____________

Adjuster's Name: ____________________ Phone: ____________

Other Driver's Insurance Information - (Other car's driver - if another car was involved)

Other Drover's Name: ____________________ Phone: ____________

Insurance Name: ____________________ Policy #: ____________ Claim #: ____________

Address: ____________________ City: ____________ ST: ______ Zip: ____________

Adjuster's Name: ____________________ Phone: ____________

WRITE LEGIBLY # SUBJECTIVE COMPLAINTS **WRITE LEGIBLY**

10 Explain **WHEN** and **HOW** it happened:____________________

20 COMPLAINTS/SYMPTOMS: ___Come and go ___Came on gradually ___Came on suddenly

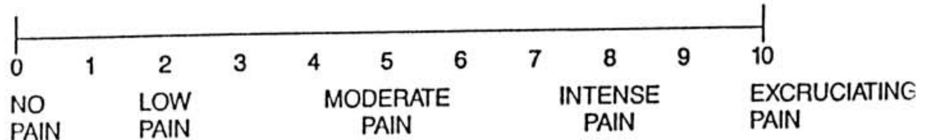
30 Symptoms have persisted for: ___Hours ___1 Day ___Days ___Weeks ___Months ___Years

40 Symptoms developed from: ___A work-related injury ___An auto accident ___Neither a work or auto accident

50 PRESENT COMPLAINTS--**PLEASE BE SPECIFIC:**____________________

____

60 **PAIN LEVEL**: On a scale of 0-10, with 0 being you're pain free and can function quite well, and 10 being you're in excruciating pain all the time, where would you rate the intensity of your pain?



70 What makes your condition worse?___Nothing ___Lifting ___Trying to stand ___Standing ___Walking ___Sitting ___Movement ___Exercise ___Inactivity ___Work activities ___Home activities ___________Other

80 What makes your condition better?___Nothing ___Standing ___Walking ___Sitting ___Movement ___Exercise ___Inactivity ___Lying down ___Sleep ___Hot shower/bath ___Stretching ___________Other

90 Have you ever had this condition/problem before? ___No

100 If yes, when?____________________

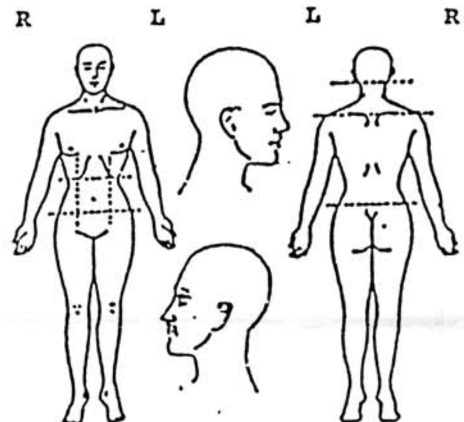
110 Give name(s) of doctor(s) previously seen for this present condition____________________

120 What medications are you presently taking?____________________

130-160 ABILITY TO PERFORM THE FOLLOWING ACTIVITIES:
CODES: **U=Unable/130 P=Painful/140 D=Difficult/150 L=Limited/150 N=Normal/160**

___Coughing or sneezing
___Getting in or out of a car
___Bending over forward
___Putting on clothes
___Putting on shoes
___Turning over in bed
___Getting out of bed
___Standing for more than 10 minutes
___Standing for more than 60 minutes
___Walking short distances
___Lying flat on stomach
___Lying on side with knees bent
___Climbing
___Kneeling
___Balancing
___Sitting
___Looking back
___Sleeping
___Stooping
___Gripping
___Pushing
___Pulling
___Reaching
___Sexual Activity

230 SHADE AND CODE AREA(S) OF COMPLAINT:
USE CODES: **P=Pain N=Numb S=Spasm**



170 CHECK YOUR NERVOUS SYSTEM COMPLAINTS

___Blurring vision
___Buzzing or ringing in ears
___Confusion
___Convulsions
___Depression or crying spells
___Dizziness
___Fainting
___Paralysis
___Headaches
___How often do you have headaches?_____
___Loss of sleep
___Low resistance
___Muscle jerking
___Numbness

240 *(WOMEN ONLY) Are you pregnant?*
Date of onset of last menstrual cycle__________

250 Give date of last X-rays:__________

What body parts were they taken of?__________

180 Symptoms are **BETTER** in: ___AM ___Midday ___PM

190 Symptoms are **WORSE** in: ___AM ___Midday ___PM

200 Symptoms do not change with time of day ___

210-220 FAMILY HISTORY: *(heart/lung/back/neck problems)*
Father: Brother(s):
Mother: Sister(s):

Name____________________ Date_______

File #__________ Occupation__________

FORM 20 REV 1/95

Copyright 1995 Michael E Whitton DC PC