

# Personal Injury History Form

Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Date of Accident \_\_\_\_\_

Please describe the accident? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What street did the accident occur on? \_\_\_\_\_

What was your position in the vehicle?

Driver  Front Passenger  Left Rear Passenger  Right Rear Passenger  \_\_\_\_\_

What type of vehicle were you in?

Car  Pickup Truck  Large Truck  Van  SUV  Station Wagon  \_\_\_\_\_

What was the other vehicle type?

Car  Pickup Truck  Large Truck  Van  SUV  Station Wagon  \_\_\_\_\_

What was your vehicle doing at the time of the accident?

Stopped at intersection  Stopped in traffic  Making a left turn  Making a right turn  
 Slowing down  Speeding up  Proceeding along  Parking  \_\_\_\_\_

What was your estimated speed at the moment of the crash? \_\_\_\_\_

What was the estimated speed of the other vehicle? \_\_\_\_\_

What time of day did the accident occur?  Dawn  Daylight  Dusk  Dark

What were the conditions of the road at the time of the crash?

Clean and Dry  Wet  Icy  Sandy  Dark  Other \_\_\_\_\_

How was your visibility at the time of the crash?  Good  Fair  Poor

Did you see the accident coming?  Yes  No      Were you braced for the impact?  Yes  No

Did you have a seatbelt on?  Yes  No      Did you have a shoulder harness on?  Yes  No

What was the position of your body at the time of the impact?

Facing straight forward  Turned to the right  Turned to the left  Leaning back  Leaning forward

Does your vehicle have headrests?  Yes  No

What was the position of your headrest at the time of the impact?

Even with top of head  Even with bottom of head  Middle of the neck

What was the direction of your head at the time of the impact?

Facing straight forward  Turned to the right  Turned to the left  Looking up  Looking down

Did airbags deploy?  Yes  No      Were you struck by the airbag?  Yes  No \_\_\_\_\_

Who hit who/what?

Other vehicle hit you  You hit other vehicle  You hit object \_\_\_\_\_

What was the point of impact?

Head-on  Rear-end  Left Front  Right Front  Left Side  Right Side  Left Rear  Right Rear

Did your body strike the inside of your vehicle?  Yes  No Describe \_\_\_\_\_

Did your vehicle strike any object after the crash?  Yes  No Describe \_\_\_\_\_

Were you wearing a hat or glasses?  Yes  No      Were they still on after the crash?  Yes  No

Did you lose consciousness during the injury?  Yes  No      For how long? \_\_\_\_\_

Where you dazed?  Yes  No

Did you feel any pain?  Yes  No Where? \_\_\_\_\_

How long after the accident? \_\_\_\_\_

Did you find any bruises?  Yes  No Where? \_\_\_\_\_

What was the estimated damage to your vehicle?  Mild  Moderate  Major \$ \_\_\_\_\_

What was the estimated damage to the other vehicle?  Mild  Moderate  Major \$ \_\_\_\_\_

Were the police called to the scene?  Yes  No Was a report made?  Yes  No

Where did you go after the accident?

Home  Work  Hospital/ ER  Private Doctor  Other \_\_\_\_\_

How did you get there?

Drove Self  Friend/Relative  Ambulance  Police  Other \_\_\_\_\_

Were X-rays done?  Yes  No Body parts X-rayed: \_\_\_\_\_

Was lab work done?  Yes  No What lab work? \_\_\_\_\_

What treatment was given?  Cervical Collar  Ice  Heat  Other \_\_\_\_\_

What medications were prescribed?  None  \_\_\_\_\_

What follow-up instructions were given?  None  \_\_\_\_\_

Check off the symptoms that you have had since the accident.

- |                                   |   |                                     |                                       |
|-----------------------------------|---|-------------------------------------|---------------------------------------|
| <input type="radio"/> Headache    | <input type="radio"/> Neck pain         | <input type="radio"/> Mid back pain | <input type="radio"/> Low back pain   |
| <input type="radio"/> Dizziness   | <input type="radio"/> Arm/leg pain      | <input type="radio"/> Nausea        | <input type="radio"/> Numbness        |
| <input type="radio"/> Confusion   | <input type="radio"/> Sleeping problems | <input type="radio"/> Diarrhea      | <input type="radio"/> Cold hands/feet |
| <input type="radio"/> Other _____ |   |                                     |                                       |

Have you been seen by any other doctors prior to your first visit to this office?  Yes  No

1. Dr. \_\_\_\_\_ First visit date \_\_\_\_\_

Specialty \_\_\_\_\_ X-rays done?  Yes  No

Types of treatments \_\_\_\_\_

How many treatments \_\_\_\_\_ Are you still being treated?  Yes  No

Did the treatment help?  Yes  No Last visit date \_\_\_\_\_

2. Dr. \_\_\_\_\_ First visit date \_\_\_\_\_

Specialty \_\_\_\_\_ X-rays done?  Yes  No

Types of treatments \_\_\_\_\_

How many treatments \_\_\_\_\_ Are you still being treated?  Yes  No

Did the treatment help?  Yes  No Last visit date \_\_\_\_\_

What duties are required of you on the job? \_\_\_\_\_

How many days have you missed work as a result of this accident? \_\_\_\_\_

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