PERSONAL INJURY PATIENT HISTORY FORM

NAME____ DATE__________________

AUTOMOBILE ACCIDENT – INSURANCE INFORMATION

Insurance Company Name______________________________Claim #:____________________
Adjuster's Name_____________________________________Phone #__________________ __
Agent's Name_______________________________________Phone #________________ ____

HISTORY OF OCCURRENCE

1. Date of accident______________Time___________AM/PM Driver of Vehicle____________________
2. Where were you seated? ☐Drivers seat ☐Front right passenger ☐Front center passenger ☐Rear left passenger ☐Rear center passenger ☐Rear right passenger
3. Who owns the car?__________________________ Year and model of car________________________
4. Description of other vehicle involved in accident____
5. What was the damage done to the car you were in? ☐Mild ☐Moderate ☐Severe ☐Total ☐Unknown
6. Visibility at the time of the accident was: ☐Poor ☐Fair ☐Good
7. The road conditions at the time of the accident were: ☐Snow/Icy ☐Wet ☐Clear ☐Dark
8. Type of accident: ☐Was hit in the.. ☐Hit another car in the.. ☐Rear ☐Right side ☐Left side ☐Front
9. If this was not a collision, please describe____

IMPACT/SEAT BELT/HEADREST/SPEED

10. Describe in your own words what happened to you upon impact:
____
11. Were you aware the accident was about to happen? ☐Yes ☐No
12. Did you brace for the impact? ☐Yes ☐No
13. Were you wearing a seat belt? ☐Yes ☐No Shoulder harness? ☐Yes ☐No
14. Did the car you were in have a headrest? ☐Yes ☐No
    If yes, what was the position of the headrest compared to your head before the accident?
    ☐Top of headrest even with **bottom** of the head
    ☐Top of headrest even with **top** of head
    ☐Top of headrest even with **middle** of the neck
15. Was the car equipped with an airbag where you were seated? ☐Yes ☐No
    If yes, did the airbag inflate? ☐Yes ☐No
    Were you injured by the inflated airbag? ☐Yes ☐No
    If yes, what were the injuries? ____
16. Was your car braking? ☐Yes ☐No
17. Was your car moving at the time of the accident? ☐Yes ☐No
    If yes, how fast would you estimate you were going? ________________MPH (estimate)
18. How fast was the other car going? _______________________MPH (estimate) ☐Don't know

HEAD AND BODY POSITION/ ABILITY TO MOVE BODY

19. Head and body position at the time of impact was:
    ☐Head turned:☐Right ☐Left ☐Head looking back ☐Head straight forward
    ☐Body straight in sitting position Body rotated: ☐Left ☐Right
20. At the time of the accident, what parts of your **head** or **body** hit what parts on the inside of your car?
____
21. As a result of the accident you were: ☐Rendered unconscious ☐Dazed, circumstances vague ☐Shaken up but could think clearly and function
22. Could you move all parts of your body? ☐Yes ☐No
    If no, what body parts could you not move, and why?____________________________________
23. Were you able to get out or the car and walk unaided? ☐Yes ☐No
    If no, why not? ____
24. Did you receive any medical assistance at the scene of the accident? ☐Yes ☐No

Illustrate below how the accident happened:

SYMPTOMS FROM ACCIDENT

25. Did you get any bleeding cuts? ☐Yes ☐No If yes, where? ____________________________________

26. Did you get any bruises: ☐Yes ☐No If yes, where?____

27. Please describe how you felt:

Immediately after the accident____

____

Later that day____

The next days____

28. Check symptoms apparent **since** the accident:

☐Headache	☐Neck pain/stiffness	☐Mid-back pain	☐Low-back pain
☐Eyes light sensitive	☐Pain behind eyes	☐Dizziness	☐Fainting
☐Sleeping problems	☐Fatigue	☐Numbness in fingers	☐Numbness in toes
☐Loss of smell	☐Loss of taste	☐Loss of memory	☐Loss of balance
☐Breath shortness	☐Ringing/Buzzing	☐Irritability	☐Depression
☐Cold hands	☐Cold feet	☐Diarrhea	☐Constipation
☐Tension	☐Nervousness	☐Anxious	☐Cold sweats
☐Chest pain	☐Facial pain	☐Clicking or Popping Jaw	

☐Other____

29.What makes your condition worse? ☐Nothing ☐Lifting ☐Trying to stand ☐Standing ☐Walking ☐Sitting ☐Movement ☐Exercise ☐Inactivity ☐Work activities ☐Home activities ☐Other____________

30.What makes your condition better? ☐Nothing ☐Standing ☐Walking ☐Sitting ☐Movement ☐Exercise ☐Inactivity ☐Lying down ☐Sleep ☐Hot shower/bath ☐Ice ☐Stretching ☐Other___________________

31.What is your ability to perform the following activities? U=unable, P=painful, L=limited, N=normal

___Coughing or sneezing	___Climbing
___Getting in or out of a car	___Kneeling
___Bending over forward	___Balancing
___Putting on clothes	___Looking back
___Putting on shoes	___Stooping
___Turning over in bed	___Gripping
___Getting out of bed	___Pushing
___Lying flat on stomach	___Pulling
___Lying on side with knees bent	___Reaching

32.Describe your complaints, name the body parts:____

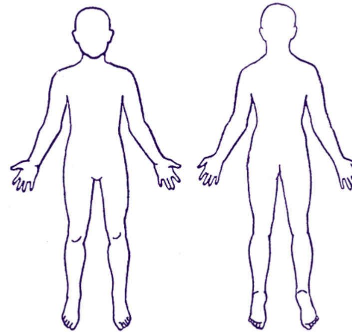
Character ☐Pain ☐Spasm ☐Tender ☐Sore ☐Ache ☐Stiff ☐Shooting ☐Weak ☐Numb

Symptoms are BETTER in ☐AM ☐Midday ☐PM

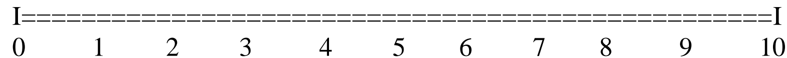
Symptoms are WORSE in ☐AM ☐Midday ☐PM ☐Symptoms do not change with time of day

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark stress points of radiation. Include all affected areas.

X numbness + burning
O pin & needles = stabbing



On a scale of 0-10, with 0 being pain free and 10 being excruciating pain, where would you rate the intensity of your pain?



WORK STATUS/HISTORY

33. Occupation:______________________________Employer:____________________________________
34. Have you missed time from work? ☐Yes ☐No
    If yes, unable to work since the accident ☐
    If yes, full time off work from _________________to____________________
    If yes, part time off work from _________________to____________________

35. Did you seek medical help immediately after the accident? ☐Yes ☐No
    If yes, how did you get there? ☐Ambulance ☐Police ☐Someone else drove me
    ☐Drove own car ☐Other____

36. **FIRST DOCTOR/HOSPITAL/CLINIC SEEN**

Name:___________________________________Date of first visit:____________________
Were you examined? ☐Yes ☐No Were x-rays taken? ☐Yes ☐No
Did you receive treatment? ☐Yes ☐No
    If yes, what kind of treatment did you receive?____
    What benefits did you receive from the treatment?____
Date of last treatment___________________________

37. **SECOND DOCTOR/HOSPITAL/CLINIC SEEN**

Name:_________________________________Date of first visit:____________________
Were you examined? ☐Yes ☐No Were x-rays taken? ☐Yes ☐No
Did you receive treatment? ☐Yes ☐No
    If yes, what kind of treatment did you receive?____
    What benefits did you receive from the treatment?____
Date of last treatment___________________________

PRIOR SIMILAR SYMPTOMS

38. Did you have any physical complaints **just before the accident**? ☐Yes ☐No
    If yes, what physical symptoms did you have **just before the accident**?
____

39. **Prior** to this accident, have you **EVER** had symptoms similar to what you are experiencing now?
☐Yes ☐No If yes, please explain(briefly include past falls, injuries, accidents, operations, etc.)
____

PAST MEDICAL HISTORY

40. Please check all that apply—
    ☐None related to current complaints ☐Hospital or operation
    ☐Auto accident ☐Work accident ☐Illness ☐Other

Describe____
____

41. Family History—Please check if any family member has had:

☐Tuberculosis	☐Kidney disease	☐Spinal disorder	☐Mental illness
☐Epilepsy	☐Diabetes	☐Gout	☐Allergy
☐Arthritis	☐Hypertension	☐Cancer	☐Migraines
☐Heart attack	☐Other, list:_______________________________________		

42. Are you pregnant? ☐Yes ☐No ☐Not sure

43. Please list any medications you are currently taking_________________________________

ACTIVITIES OF DAILY LIVING ASSESSMENT

The following questions are designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please check one item in each section that most closely applies to you.

SECTION 1: PAIN INTENSITY

☐I can tolerate the pain I have without using painkillers
☐The pain is bad, but I mange without taking painkillers
☐Painkillers give complete relief form pain
☐Painkillers give moderate relief from pain
☐Painkillers give very little relief from pain
☐Painkillers give no relief from pain and I do not use them

SECTION 2: PERSONAL CARE (washing, dressing, etc.)

☐I can look after myself normally without causing extra pain
☐I can look after myself normally, but it causes extra pain
☐It is painful to look after myself and I am slow and careful
☐I need some help, but manage most of my personal care
☐I need help every day in most aspects of self care
☐I do not get dressed, wash with difficulty, and stay in bed

SECTION 3: LIFTING

☐I can lift heavy weights without extra pain
☐I can lift heavy weights, but it causes extra pain
☐Pain prevents me from lifting heavy weights off the floor, but I can manage if the are on a table
☐Pain prevents me from lifting heavy weights, but I can manage light to medium weights
☐I can lift only very light weights
☐I cannot lift or carry anything at all

SECTION 4: WALKING

☐Pain does not prevent me from walking any distance
☐pain prevents me from walking more than one mile
☐Pain prevents me from walking more than ½ mile
☐Pain prevents me from walking more than ¼ mile
☐I can only walk using a cane or crutches
☐I am in bed most of the time and have to crawl to the toilet

SECTION 5: SITTING

☐I can sit in any chair as long as I like
☐I can only sit in my favorite chair as long as I like
☐Pain prevents me from sitting for more than one hour
☐Pain prevents me from sitting for more than 30 minutes
☐Pain prevents me from sitting for more than 10 minutes
☐Pain prevents me from sitting at all

SECTION 6: STANDING

☐I can stand as long as I want without extra pain
☐I can stand as long as I want, but it causes extra pain
☐Pain prevents me from standing for more than one hour
☐Pain prevents me from standing for more than 30 minutes
☐Pain prevents me from standing for more than 10 minutes
☐Pain prevents me from standing at all

SECTION 7: SLEEPING

- ☐Pain does not prevent me from sleeping well
- ☐I can sleep well only by using tablets
- ☐Even when I take tablets I have less than 6 hours sleep
- ☐Even when I take tablets I have less than 4 hours sleep
- ☐Even when I take tablets I have less than 2 hours sleep
- ☐Pain prevents me from sleeping at all

SECTION 8: SEX LIFE

- ☐My sex life is normal and causes no extra pain
- ☐My sex life is normal and causes some extra pain
- ☐My sex life is nearly normal, but is very painful
- ☐My sex life is severely restricted by pain
- ☐My sex life is nearly absent because of pain
- ☐Pain prevents any sex life at all

SECTION 9: SOCIAL LIFE

- ☐My social life is normal and gives me no extra pain
- ☐My social life is normal, but increases the degree of pain
- ☐Pain has no significant effect on my social life apart from limiting my more energetic interests
- ☐Pain has restricted my social life and I do not go out as often
- ☐Pain has restricted my social life to my home
- ☐I have no social life because of pain

SECTION 10: TRAVELING

- ☐I can travel anywhere without extra pain
- ☐I can travel anywhere, but it gives me extra pain
- ☐Pain is bad, but I manage journeys over 2 hours
- ☐Pain restricts me to journeys of less than one hour
- ☐Pain restricts me to short necessary trips under a half hour
- ☐Pain restricts me from traveling except to the doctor or hospital

Do you have an attorney on this claim? ☐Yes ☐No

If yes, who? ____Phone #:__________________

Patients involved in litigation (law suits) or third party payment are ultimately responsible for payment for services.

I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

MY SIGNATURE IS AN ACKNOWLEDGMENT THAT I HAVE READ THE ABOVE, AND AGREE TO ABIDE BY SAME.

Patient Signature____Date__________________

GUARDIAN SIGNATURE____
(If patient is under 18)