Personal Injury Initial History

Name_____ Date _____/_____/_____

Date of Accident _____ Time of Accident _____

Describe the accident (where, how and speed) _____
_____
_____

Describe the accident in terms of your body position before, during and immediately after the accident. Also describe any injury immediately after the accident._____
_____
_____
_____
_____
_____

To Review:
What was your position in the vehicle? _____Driver _____ Passenger
If passenger, were you sitting in:_____ Front _____Right Rear _____left Rear

Did your vehicle strike the other vehicle? _____Yes _____No
Was your vehicle struck by the other vehicle? _____Yes _____No
Was the impact from: _____the front? _____ the right side? _____the left side? _____ the rear?
After the impact did you hit another vehicle ____Yes _____No
At the time of the impact were you: _____looking straight ahead? ____ looking right _____looking left?
Were both hands on steering wheel? _____Yes _____No Was your foot on brake _____Yes _____ No
Were you braced for impact? ____Yes ____ No Were you wearing seat belt? ____Yes _____No
Where in the vehicle were you after the accident? _____
Did you strike anything in the vehicle at the time of impact? _____ Yes _____No
If yes Specify what you hit and with what part of your body:_____
_____
_____
_____

Immediately following the accident how did you feel? _____
Were you unconscious? ____ Yes ____ No In a daze? ____Yes ____No
Did you go to the hospital? ____ Yes ____ No
If you went to the hospital, when? ____at time of accident ____ next day ____ other, please
How did you get to the hospital? ____ambulance ____ private transportation
Did the ambulance attendants place you in: ____ neck collar ____ splints ____ brace

Name of Hospital _____ Attended by Dr. _____
Were you x-rayed ____Yes____No Do you know the findings, if so what were they?
_____Were admitted to the hospital? ____Yes ____No
How long did you stay? _____
What treatment was rendered? _____
What recommendations were made? ____ See own doctor? _____ See Orthopedic
Physical therapy? ____Yes ____No
Have you seen any doctor as a result of this accident? _____Yes _____No Doctor's Name_____

Please check all boxes that apply to your condition(s), and fill in the spaces that describe your present complaints(s). Also, the information you provide concerning past symptoms will help in assisting the doctor to better understand your present condition and total health picture.

Please list your present complaint(s) in order of importance.	Date you first noticed	Mark your level of pain today for each complaint, in which"0" - "4" is a range of tightness and discomfort: "5"-"10" is a range of pain where "10" is the worst pain imaginable.	Please check the box below that best represents how much of the time you feel pain or your symptoms for the listed complaint.
1		0 1 2 3 4 5 6 7 8 9 10	☐76-100% ☐51-75% ☐26-50% ☐25% or less
2		0 1 2 3 4 5 6 7 8 9 10	☐76-100% ☐51-75% ☐26-50% ☐25% or less
3		0 1 2 3 4 5 6 7 8 9 10	☐76-100% ☐51-75% ☐26-50% ☐25% or less
4		0 1 2 3 4 5 6 7 8 9 10	☐76-100% ☐51-75% ☐26-50% ☐25% or less

Mark what makes **your symptoms better with a "B"** and what makes **your symptoms worse with a "W"**

1 ___Heat ___Cold ___Rest ___Walking ___Lying down ___Standing ___Sitting ___Changing position
2 ___Heat ___Cold ___Rest ___Walking ___Lying down ___Standing ___Sitting ___Changing position
3 ___Heat ___Cold ___Rest ___Walking ___Lying down ___Standing ___Sitting ___Changing position
4 ___Heat ___Cold ___Rest ___Walking ___Lying down ___Standing ___Sitting ___Changing position

Check the best and worse times of the day for your pain. (B or W)

___First awake ___evening
___morning ___nighttime
___afternoon ___other

1. Previous Treatment_____

_____

_____

_____

2. What things can you NOT DO now?

_____

_____

_____

_____

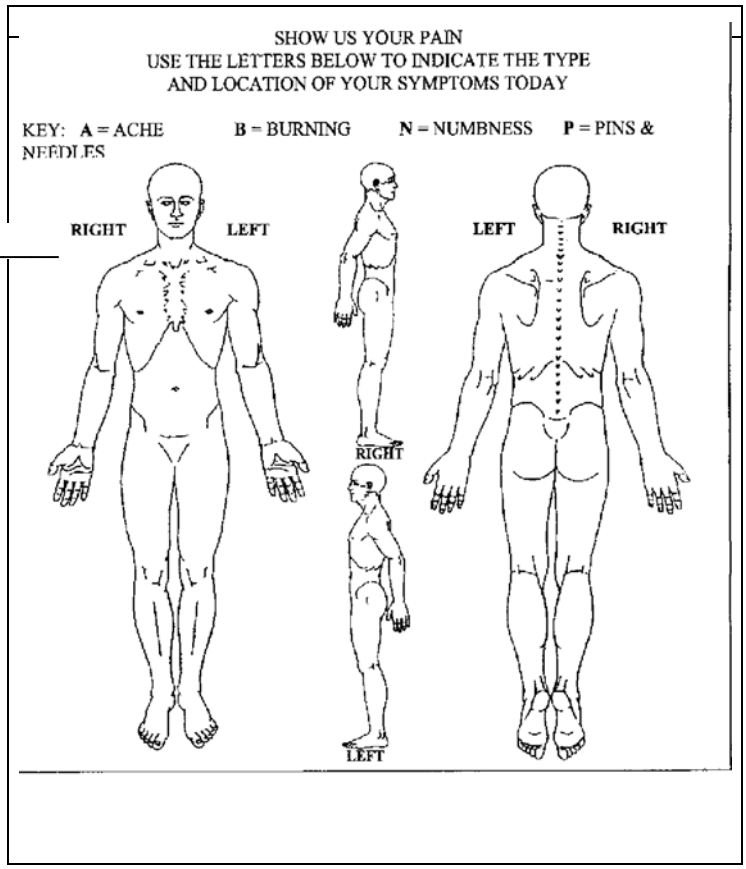
3. What things can you do with difficulty?

_____

_____

_____

_____



Is your pain worse when raising from a chair? ____Yes ____No
Is it made worse by straining ? ____Yes ____No Coughing? ____Yes ____No
Sneezing ____Yes ____No By straining when moving our bowels? ____Yes ____No
What is your most comfortable position? __Sitting __ Lying on your left __ Lying on right
____Lying on your back ____On your stomach ____Standing Other_____
Difficult when lying in bed? ____Yes ____No
When stretching & twisting does pain worsen ____Yes ____No
Are you taking any medication, and if so for what? _____

_____

_____

Are you taking vitamins, and if so for what? _____

_____

Have you lost any time from work because of this accident ___Yes ___No
If so give dates from and to:_____

Please go to next page

Please continue ...

a. During what time of the day do you feel worse? _____

b. Do you sleep well? ❑ Yes ❑No What are your normal sleeping hours? _____to _____

c. Are you currently under the care of a medical doctor or other type of health care provider for any condition?
❑ No ❑ Yes → For what condition? _____

Name of doctor/provider _____ Phone number _____

d. Have you ever had an overnight stay in a hospital or a surgical procedure of any kind?
❑ No ❑ Yes If yes, please describe each event below:

Event _____ Year _____

Event _____ Year _____

e. Do you exercise? ❑ Yes ❑ No If yes, please describe activity _____

How many days a week? _____ How many minutes per session?_____

Personal history

The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

Pain in body

- ❑ Neck pain with difficulty swallowing
- ❑ Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck
- ❑ Leg pain that worsens with exercise but is relieved by resting
- ❑ Loss of feeling in inner thighs
- ❑ Back pain with urinary problems

Types of pain

- ❑ Severe pain interrupts sleep
- ❑ Constant pain that doesn't improve by changing positions or lying down

Current conditions

- ❑ Unable to balance when walking
- ❑ Recent unexplained weight loss
- ❑ Recent progressive muscle weakness or shaking
- ❑ Recent or current fever over 102°F
- ❑ Loss of bowel or bladder control
- ❑ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- ❑ Recent major accident such as a fall from height, whiplash or blow to the head
- ❑ Memory loss after injury

Previously diagnosed condition/ medical history

- ❑ Congenital bone or joint disorder
- ❑ Rheumatoid arthritis
- ❑ Severe degenerative arthritis
- ❑ History of compression fracture
- ❑ History of heart attack
- ❑ History of stroke or aneurysm
- ❑ Past history of cancer or currently diagnosed with cancer
- ❑ Diabetes with cold, burning or numb feet
- ❑ Gout
- ❑ Lupus
- ❑ Ankylosing spondylitis
- ❑ Immune suppression such as from chemotherapy, organ transplant, etc.
- ❑ 3 or more months use of steroid medications or intravenous drugs (past or recent)

Family history

❑ Autoimmune disorders ❑ Cancer ❑ Heart disease ❑ Mental illness
❑ Arthritis ❑ Diabetes ❑ Kidney disease ❑ Seizure disorder

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.

Signature _____ Today's date:____/____/____

If patient required assistance to complete, sign name and state relationship (i.e., parent, translator) below:

Name _____ Relationship _____ Today's date:____/____/____