Personal Injury History

CHIROPRACTIC
Healthcare Center
All Injury Solution

1. HISTORY

Name _____ **Date** _____

Date of accident _____ **Was the accident related to work?** ☐ Y ☐ N **Time** _____ am/pm

Road Conditions ☐ Icy ☐ Wet ☐ Dry **Police report filed?** ☐ Y ☐ N **# of people in vehicle** _____

Vehicle you occupied ☐ Car ☐ Pickup ☐ SUV ☐ Commercial Truck ☐ 18-Wheeler

Other vehicle ☐ Car ☐ Pickup ☐ SUV ☐ Commercial Truck ☐ 18-Wheeler

Position ☐ Driver ☐ Passanger **Sitting in the** ☐ Front seat ☐ Back seat **On the** ☐ Left ☐ Right ☐ Center

Seatbelt ☐ Y ☐ N **Did the airbay deploy?** ☐ Y ☐ N **Were you aware that the accident was about to occur?** ☐ Y ☐ N

Area of vehicle sustaining inpact ☐ Rear ☐ Front ☐ Left ☐ Right ☐ Center

After the initial collision, did any other vehicles strike your vehicle, or did your vehicle hit another vehicle or object? ☐ Y ☐ N

If yes, please explain _____

2. HISTORY OF VEHICLE ACCIDENT

Please provide a diagram of the collision. Mark your car "A," then the other car "B," etc.

As a result of the impact, your body was thrown

☐ Back, then forward ☐ Forward, then back ☐ Left ☐ Right ☐ Forward ☐ Back

As a result of the accident, your body sustained the following impacts

Head struck	☐ Headrest	☐ Steeringwheel	☐ Dash	☐ Windshield	☐ None
Face struck	☐ Steeringwheel	☐ Dash	☐ Windshield	☐ None	
Chest struck	☐ Steeringwheel	☐ Dash	☐ Windshield	☐ None	
Knees struck	☐ Back of front seat	☐ Dash	☐ Windshield	☐ None	
Left shoulder stuck	☐ Window	☐ Door	☐ Passenger	☐ None	
Right shoulder struck	☐ Window	☐ Door	☐ Passenger	☐ None	

Loss of consciousness
☐ Y ☐ N

As a result of the accident, your body sustained the following injuries: bruise, cut, burn, broken bone, or other

Head _____ **Face** _____

Chest _____ **Knees** _____

Left shoulder _____ **Right shoulder** _____

Left hand _____ **Right hand** _____

Symptoms experienced during accident _____

Symptoms experienced immediately following the accident _____

Symptoms experienced later that day _____

Symptoms experienced the following day _____

Personal Injury History (Continued)

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2. HISTORY OF VEHICLE ACCIDENT (CONTINUED)

Since the accident, the symptoms have ☐ Increased ☐ Decreased ☐ Remained the same

Previous treatment you have received for the injuries sustained in this accident

Ambulance ☐ Y ☐ N

Emergency room ☐ Y ☐ N Date(s) _____ - _____ - _____ Facility _____

Medical clinic ☐ Y ☐ N Date(s) _____ - _____ - _____ Facility _____

Medications prescribed ☐ Y ☐ N _____

Diagnostic Text X-ray ☐ Y ☐ N If yes, what region of the body _____

Other ☐ Y ☐ N If yes, please describe _____

Follow-up with doctor ☐ Y ☐ N Other _____

Return to hospital ☐ Y ☐ N _____

Have you suffered from any of the following types of illnesses, accidents, or injuries, or obtained the following medical procedures within the past ten years? If yes, please describe the procedure

Worker's Compensation ☐ Y ☐ N _____

Motor Vehicle Collision ☐ Y ☐ N _____

Slip-and-fall ☐ Y ☐ N _____

Fractures or broken bones ☐ Y ☐ N _____

Surgeries ☐ Y ☐ N _____

Perscription medication ☐ Y ☐ N If yes, please identify the medication(s) and the condition(s) for which the medication(s) has/have been prescribed and the date the medication(s) was/were last taken _____

_____

_____

Identify any of the following symptoms you have been experiencing since the accident/injury

Fatigue ☐ Y ☐ N **Emotional disturbance** ☐ Y ☐ N Describe _____

Irritability ☐ Y ☐ N **Difficulty sleeping** ☐ Y ☐ N **Swelling** ☐ Y ☐ N Location _____

Nervousness ☐ Y ☐ N **Weakness** ☐ Y ☐ N Location _____

3. JOB DESCRIPTION AND WORK STATUS

Name _____ **Date** _____ ☐ M ☐ F

Job Description _____ **Title** _____

Sit (hrs. per day) _____ **Stand** (hrs. per day) _____ **Lift** (lbs.) _____

Have you missed any work as a result of the accident? ☐ Y ☐ N **If yes, how many days?** _____

Doctor's Notes _____

_____

Doctor's signature _____