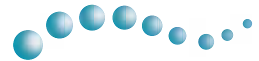
Personal Injury History



Name ______________________________ **Date** ______________

1. HISTORY

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 ☐Passenger **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 impact ☐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

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** ______________ ☐ **Face** ______________

☐ **Chest** ______________ ☐ **Other** ______________

☐ **Left shoulder** ______________ ☐ **Other** ______________

Loss of consciousness ☐Y ☐N **Symptoms experienced during accident** ______________

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** ______________ ☐ **Other** ______________

☐ **Left hand** ______________ ☐ **Other** ______________

As a result of the accident, your body sustained injuries to the following areas

☐ **Headaches** ______________ ☐ **Pelvic pain** ☐L ☐R ______________

☐ **Neck pain** ______________ ☐ **Hip pain** ☐L ☐R ______________

☐ **Chest pain** ______________ ☐ **Thigh pain** ☐L ☐R ______________

☐ **Mid back pain** ______________ ☐ **Knee pain** ☐L ☐R ______________

☐ **Low back pain** ______________ ☐ **Leg pain** ☐L ☐R ______________

☐ **Shoulder pain** ☐L ☐R ______________ ☐ **Ankle pain** ☐L ☐R ______________

☐ **Elbow pain** ☐L ☐R ______________ ☐ **Foot pain** ☐L ☐R ______________

☐ **Wrist pain** ☐L ☐R ______________ ☐ **Jaw pain** ☐L ☐R ______________

☐ **Hand pain** ☐L ☐R ______________ ☐ **Other** ______________

Previous history of same or similar complaints ☐Y ☐N ______________

Personal Injury History (Continued)

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 ____________________

Prescription 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

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 ____________________

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Reviewed by ____________________ **Signature** ____________________