



PERSONAL INJURY-PATIENT HISTORY

HISTORY OF OCCURRENCE, PLEASE PRINT:

NAME: _____ DATE: _____

DATE OF ACCIDENT: _____ TIME: _____ AM PM

WHERE DID THE ACCIDENT OCCUR? _____

DESCRIBE IN YOUR OWN WORDS WHAT HAPPENED TO YOU: _____

IF YOU WERE STRUCK BY SOMETHING, WHAT PART OF THE BODY WAS STRUCK? _____

YES NO WERE YOU MOVING? WERE YOU: SITTING STANDING LYING WALKING

WHAT ACTIVITY (IF ANY) WERE YOU ENGAGED IN AT THE TIME OF THE ACCIDENT? (BASEBALL, SPECTATOR, RACING, ETC.) _____

AS A RESULT OF THE ACCIDENT, WERE YOU:

RENDERED UNCONSCIOUS DAZED, SITUATION VAGUE SHAKEN UP BUT COULD FUNCTION

YES NO COULD YOU MOVE ALL PARTS OF YOUR BODY? IF NO, WHAT PARTS AND WHY NOT? _____

YES NO WERE YOU ABLE TO GET UP AND WALK UNAIDED? IF NO, WHY NOT? _____



SYMPTOMS FROM ACCIDENT

YES NO DID YOU RECEIVE BLEEDING CUTS OR BRUISES? IF CUTS, WHERE? _____
IF BRUISES, WHERE? _____

PLEASE DESCRIBE HOW YOU FELT. PLEASE BE SPECIFIC.

IMMEDIATELY AFTER THE ACCIDENT: _____

LATER THAT DAY NIGHT: _____

THE NEXT DAY(S): _____



GENERAL SYSTEMS UPDATE

- CHECK SYMPTOMS THAT HAVE BECOME APPARENT SINCE THE ACCIDENT/INJURY:
- | | | | |
|---|--|---|--|
| 1. <input type="checkbox"/> NERVOUSNESS | 11. <input type="checkbox"/> LOSS OF BALANCE | 21. <input type="checkbox"/> SLEEPING TROUBLE | 32. <input type="checkbox"/> HEADACHE |
| 2. <input type="checkbox"/> NECK PAIN/STIFFNESS | 12. <input type="checkbox"/> LOSS OF SMELL | 22. <input type="checkbox"/> TOE NUMBNESS | 33. <input type="checkbox"/> FAINTING |
| 3. <input type="checkbox"/> MIDBACK PAIN | 13. <input type="checkbox"/> LOSS OF TASTE | 23. <input type="checkbox"/> FINGER NUMBNESS | 34. <input type="checkbox"/> ANXIETY |
| 4. <input type="checkbox"/> LOW BACK PAIN | 14. <input type="checkbox"/> LOSS OF MEMORY | 24. <input type="checkbox"/> COLD HANDS | 35. <input type="checkbox"/> SEIZURES |
| 5. <input type="checkbox"/> EYES SENSITIVE TO LIGHT | 15. <input type="checkbox"/> PINS & NEEDLES - ARMS | 25. <input type="checkbox"/> COLD FEET | 36. <input type="checkbox"/> VISUAL DISTURBANCES |
| 6. <input type="checkbox"/> PAIN BEHIND EYES | 16. <input type="checkbox"/> PINS & NEEDLES - LEGS | 26. <input type="checkbox"/> CHEST PAIN | 37. <input type="checkbox"/> FORGETFULNESS |
| 7. <input type="checkbox"/> DIZZINESS | 17. <input type="checkbox"/> SHORTNESS OF BREATH | 27. <input type="checkbox"/> CONSTIPATION | 38. <input type="checkbox"/> BLURRED VISION |
| 8. <input type="checkbox"/> COLD SWEATS | 18. <input type="checkbox"/> HEAD SEEMS TOO HEAVY | 28. <input type="checkbox"/> DIARRHEA | 39. <input type="checkbox"/> DOUBLE VISION |
| 9. <input type="checkbox"/> FACE FLUSHED | 19. <input type="checkbox"/> IRRITABILITY | 29. <input type="checkbox"/> FATIGUE | 40. <input type="checkbox"/> CONFUSED |
| 10. <input type="checkbox"/> RINGING/BUZZING EARS | 20. <input type="checkbox"/> DEPRESSION | 30. <input type="checkbox"/> TENSION | 41. <input type="checkbox"/> DISORIENTED |
| | | 31. <input type="checkbox"/> FEVER | 42. <input type="checkbox"/> OTHER _____ |



MECHANISM OF INJURY

PLEASE EXPLAIN THE MECHANISM OF THE INJURY (ONLY FILL IN THOSE SECTIONS THAT APPLY TO YOU):

FALL:

- A) YES NO DID YOU HIT ANYTHING WHEN YOU FELL? IF YES, WHAT? _____
- B) YES NO WERE YOU CARRYING ANYTHING WHEN YOU FELL? IF YES, WHAT? _____
HOW MUCH DID IT WEIGH? _____ LBS.
- C) YES NO DID YOU TWIST WHEN YOU FELL? IF SO, TO WHICH SIDE? LEFT RIGHT
- YES NO DID IT LAND ON YOU? IF YES, WHERE? _____
- D) YES NO WAS THE AREA LIGHTED? _____
- E) DESCRIBE THE CONDITION OF THE AREA (SLIPPERY, GRAVELED, ETC.) _____
- F) WHAT PART OF THE BODY DID YOU FALL ON? _____
- G) HOW FAR DID YOU FALL? (FT.) _____
- H) WHAT DID YOU LAND ON? _____

LIFT/PULL:

- A) HOW MUCH DID THE OBJECT WEIGH? _____ LBS.
- B) YES NO DID YOU FALL AFTER THE INJURY? IF YES, HOW FAR? _____
 YES NO DID YOU HIT ANYTHING WHEN YOU FELL? WHAT? _____
- C) YES NO WERE YOU TWISTING WHEN YOU WERE LIFTING/PULLING? WHICH WAY? LEFT RIGHT
- D) HOW FAR OFF THE GROUND DID YOU HAVE THE OBJECT BEFORE THE PAIN STARTED? _____

(CONTINUED)

- E) YES NO DID YOU DROP THE OBJECT WHEN THE PAIN STARTED?
 YES NO DID IT LAND ON YOU? WHERE? _____
- F) DID YOU LIFT WITH YOUR LEGS BACK OTHER _____

BEND:

- A) YES NO WERE YOU LIFTING WHEN YOU WERE BENT OVER? IF YES, HOW MUCH DID THE OBJECT WEIGHT? _____ LBS.
 B) HOW FAR WERE YOU BENT OVER? _____
 C) YES NO DID YOU FALL WHEN THE PAIN STARTED? HOW FAR? _____
 D) YES NO WERE YOU TWISTING WHEN YOU BENT FORWARD? TOWARD WHICH SIDE? LEFT RIGHT



WORK STATUS HISTORY

OCCUPATION: _____ EMPLOYER: _____
 YES NO HAVE YOU MISSED TIME FROM WORK? IF NO, WHO TOLD YOU TO RETURN TO WORK? _____
 IF YES, OFF WORK FULL-TIME DATES: _____
 OFF WORK PART-TIME DATES: _____
 UNABLE TO RETURN TO WORK SINCE ACCIDENT.
 WHAT TYPE OF PHYSICAL ACTIVITY IS REQUIRED AT WORK? _____



FIRST DOCTOR/HOSPITAL/CLINIC

YES NO DID YOU SEEK MEDICAL HELP IMMEDIATELY AFTER THE ACCIDENT? IF YES, HOW DID YOU GET THERE?
 SOMEONE ELSE DROVE ME DROVE OWN CAR POLICE AMBULANCE
 DOCTOR/HOSPITAL/CLINIC: _____ DATE OF FIRST VISIT: _____
 YES NO WERE YOU EXAMINED? YES NO WERE X-RAYS TAKEN?
 WHAT DIAGNOSIS DID THE DOCTOR GIVE YOU? _____
 YES NO WERE YOU GIVEN TREATMENT? IF YES, WHAT TYPE? _____
 WHAT BENEFITS DID YOU RECEIVE FROM THIS TREATMENT? _____
 YES NO DID THE TREATMENT LAST?
 YES NO DID THE DOCTOR REFER YOU TO ANOTHER HEALTH PROFESSIONAL? IF YES, TO WHO AND FOR WHAT? _____
 YES NO DID YOU FOLLOW THE DOCTOR'S RECOMMENDATION? IF NO, WHY NOT? _____



SECOND DOCTOR/CLINIC

DOCTOR/CLINIC: _____ DATE OF FIRST VISIT: _____
 YES NO WERE YOU EXAMINED? YES NO WERE X-RAYS TAKEN?
 YES NO WERE YOU GIVEN TREATMENT? IF YES, WHAT TYPE? _____
 WHAT BENEFITS DID YOU RECEIVE FROM THIS TREATMENT? _____
 DATE OF LAST TREATMENT: _____



PRIOR SIMILAR SYMPTOMS

YES NO DID YOU HAVE ANY PHYSICAL COMPLAINTS BEFORE THE ACCIDENT? IF YES, PLEASE DESCRIBE IN DETAIL: _____
 YES NO PRIOR TO THIS ACCIDENT, HAVE YOU EVER HAD SIMILAR SYMPTOMS? IF YES, PLEASE EXPLAIN (FALLS, INJURIES, ETC.) _____
 YES NO HAVE YOU BEEN IN ACCIDENTS PRIOR TO THIS ONE? IF YES, WHEN? _____ WHERE? _____
 HOW WAS IT TREATED? _____ RESULT OF TREATMENT: _____
 YES NO ARE YOU NOW BEING TREATED?
 YES NO DO YOU HAVE ANY CONGENITAL (BIRTH) FACTORS WHICH RELATE TO THIS PROBLEM? IF YES, PLEASE DESCRIBE: _____

ADDITIONAL COMMENTS: