

PERSONAL INJURY – PATIENT DATA FORM

Name _____ Date _____

Date of Accident : _____ Time: _____ (AM/PM)

Driver of car : _____ Where were you seated : _____

Who owns the car : _____ Year and model of car : _____

What was the approximate damage done to your car? \$ _____

Visibility at the time of accident : poor / fair / good / other : _____

Road conditions at time of accident : icy / rainy / wet / clear / dark

Where was your car struck ? right / left / rear / front / side / other : _____

Type of accident : head – on collision broad – side collision
 rear – end collision front impact, rear – ended car in front
 non – collision : _____

Describe in your own words what happened to you upon impact : _____

Did you see the accident coming ? Yes / No

Did you brace for impact ? Yes / No

Were seat belts worn ? Yes / No

Were shoulder harnesses worn ? Yes / No

Does your car have headrest ? Yes / No

If yes, what was the position of those head rests compared to your head before the accident?

top of headrest even with bottom of head

top of headrest even with top of head

top of headrest even with middle of neck

Was your car braking ? Yes / No

Was your car moving at the time of the accident ? Yes / No

If yes, how fast would you estimate you were going ? _____ m.p.h. (estimate)

How fast was the other car traveling ? _____ m.p.h. (estimate)

Head / Body position at time of impact:

head turned left / right body straight in sitting position

head looking back body rotated left / right

head straight forward other : _____

At the time of accident, recall what parts of your head or body hit what parts on the inside of your car :

As a result of the accident you were :

rendered unconscious dazed, circumstances vague other : _____

Could you move all parts of your body ? Yes / No

If no, what parts and why ? _____

Were you able to get out of the car unaided ? Yes / No

If no, why not ? _____

Did you get any bleeding cuts or bruises ? Yes/ No

If yes, what bleeding cuts did you get from this accident ? _____

If yes, what bruises did you get from this accident ? _____

Please describe how you felt. Please be specific. Immediately after the accident : _____

Later that day : _____ Night : _____

The next day : _____ Night : _____

Check symptoms apparent since the accident:

- | | | |
|---|--|--|
| <input type="checkbox"/> headache | <input type="checkbox"/> loss of smell | <input type="checkbox"/> numbness in fingers |
| <input type="checkbox"/> neck pain / stiffness | <input type="checkbox"/> loss of taste | <input type="checkbox"/> cold hands |
| <input type="checkbox"/> mid back pain | <input type="checkbox"/> loss of memory | <input type="checkbox"/> cold feet |
| <input type="checkbox"/> low back pain | <input type="checkbox"/> fatigue | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> eyes sensitive | <input type="checkbox"/> tension | <input type="checkbox"/> constipation |
| <input type="checkbox"/> pain behind eyes | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> chest pain |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> irritability | <input type="checkbox"/> nervousness |
| <input type="checkbox"/> fainting | <input type="checkbox"/> depression | <input type="checkbox"/> cold sweats |
| <input type="checkbox"/> ringing / buzzing ears | <input type="checkbox"/> sleeping problems | <input type="checkbox"/> anxious |
| <input type="checkbox"/> loss of balance | <input type="checkbox"/> numbness in toes | <input type="checkbox"/> other |

Occupation : _____ Employer : _____

Have you missed time from work ? Yes / No

If , yes

Full time off work from _____ to _____ : from _____ to _____

Part time off work from _____ to _____ : from _____ to _____

Been unable to work since accident : _____

Did you seek medical help immediately / soon after the accident ? Yes / No

If yes, how did you get there ? Someone else drove me Ambulance

Drove own car Police

DOCTOR 1 / HOSPITAL / CLINIC SEEN : _____ Date of first visit : _____

Were you examined ? Yes / No Were X-rays taken ? Yes / No

Were you given treatment ? Yes / No

What benefits did you receive from this treatment ? _____

_____ Date of last treatment : _____

DOCTOR 2 / CLINIC SEEN : _____ Date of first visit : _____

Were you examined Yes / No Were X-rays taken ? Yes / No

Were you given treatment ? Yes / No

What benefits did you receive from this treatment ? _____

_____ Date of last treatment : _____

DOCTOR 3 / CLINIC SEEN : _____ Date of first visit : _____

Were you examined Yes / No Were X-rays taken ? Yes / No

Were you given treatment ? Yes / No

What benefits did you receive from this treatment ? _____

_____ Date of last treatment : _____

Did you have any physical complaints **JUST** BEFORE THE ACCIDENT ? Yes / No

If yes, please describe in detail : _____

PRIOR to this accident, have you EVER had symptoms similar to what you're experiencing now ? Yes / No

If yes, please explain : _____

(briefly include past falls, injuries, accidents, operations, etc.)

Do you notice any activities of your home daily routines that are difficult now than from before the accident ? Yes / No

If yes, list them as :

Those that you are unable to do are : (be specific) _____

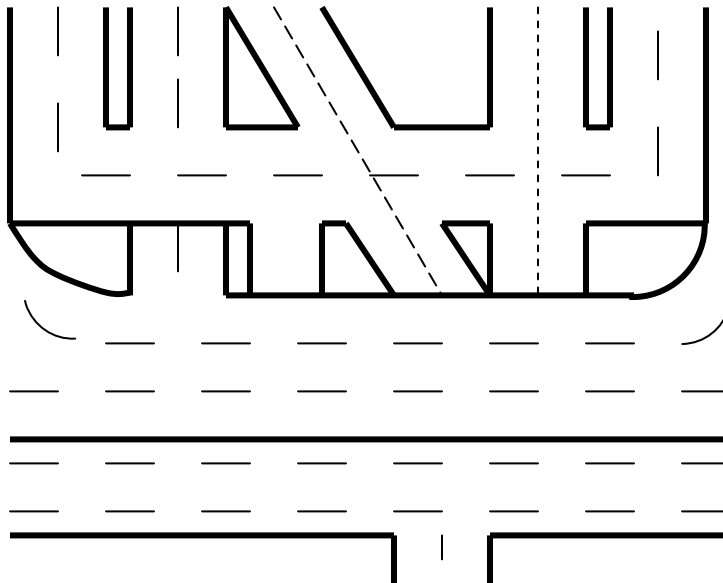
Those that are painful to do are : (be specific) _____

Those that are difficult to do are : (be specific) _____

On a scale from 1 – 5 with 1 being 9examinee’s quote) “I’m pain free and can function quite well,” and 5 being “I’m in pain all the time and cannot function at all,” where would you rate yourself ? 1 2 3 4 5

Please explain why : _____

Relative to where you were before this injury, how would you rate how much you have recovered so far ? _____ %



Indicate on this diagram
How the accident happened

Do you have an attorney on this case ? Yes / No If yes, who ?

Name _____ Address _____

City _____ State _____ Zip _____ Phone _____

Automobile accident – Insurance Information

Patient’s Insurance Company Information :

Company Name : _____ Phone : _____ Policy # : _____

Address : _____

Adjuster Name : _____ Claim # : _____

Insured’s Insurance Information

Insured’s name if different from patient : _____ Phone : _____

Company Name : _____ Phone : _____ Policy # : _____

Address : _____

Adjuster Name : _____ Claim # : _____

Other Driver’s Insurance Information

Other driver’s name : _____ Phone : _____

Company Name : _____ Phone : _____ Policy # : _____

Address : _____

Adjuster Name : _____ Claim # : _____

Patient Signature

Date

