PERSONAL INJURY PATIENT HISTORY

NAME_____DATE_____FILE#_____

1. HISTORY OF OCCURRENCE

1a.Date of Accident: _____ Time: _____ ☐AM ☐PM

Driver of Car: _____ What seat were you sitting in? _____

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

What was the approximate damage done to the car you were in? ($) _____

1b. Visibility at time of accident: ☐Poor ☐Fair ☐Good

Road conditions at time of accident: ☐Icy ☐Rainy ☐Wet ☐Clear ☐Dark

Your Car: ☐Was hit in the ☐Hit another car in the: ☐Rear ☐Right ☐Left ☐Front ☐Side

Type of accident: ☐Head-On Collision ☐Broad-side collision ☐Rear-end collision

☐Front impact, rear-ended car in front

☐Non-collision: _____

2. IMPACT/ SEAT BELT/ HEADREST/ SPEED

2a. Describe in your own words what happened to you upon impact: _____

_____

Were you aware the accident was about to happen? ☐Yes ☐No

Did you brace for the impact? ☐Yes ☐No

Were you wearing a seat belt/shoulder harness? ☐Yes ☐No

2b. Did the car you were in have headrests? ☐Yes ☐No

2c. If yes, what was the position of the headrest compared to your head before the accident?

☐Top of headrest even with bottom of the head ☐Top of headrest even with top of the head

☐Top of headrest even with middle of the neck

2d. Was your car braking? ☐Yes ☐No

2e. Was your car moving at the time of the accident? ☐Yes ☐No

2f. If yes, how fast would you estimate you were going? _____MPH (estimate)

2g. How fast was the other car traveling? _____MPH (estimate)

3. HEAD/BODY POSITION / ABLE TO MOVE BODY

3a. Head/Body position at time of impact: ☐Head turned: ☐Right ☐Left ☐Head looking back

☐Head straight forward ☐Body straight in the sitting position ☐Body rotated: ☐Right ☐Left

3b. At the time of accident, recall what parts of your head or body hit what parts on the inside of your car: _____

_____

3c. As a result of the accident were you: ☐Rendered unconscious ☐Dazed, circumstances vague

☐Shaken up but could think clearly and function

3d. Could you move all parts of your body? ☐Yes ☐No

3e. If no, what body parts could you not move and why? _____

60 Were you able to get out of the car and walk unaided? ☐Yes ☐

70 If no, why couldn't you get out of the car and walk unaided? _____

Chantilly Chiropractic Center, P.C., 3910 Centreville Rd. #202, Chantilly, VA 20151 (703) 378-2698; Dr. Wm. Todd Fisher; Dr. Gregory Page; Dr. Daniel Robinson

4. SYMPTOMS FROM ACCIDENT

4a. Did you get any bleeding cuts or bruises? ☐ Yes ☐No
4b. If yes, what **bleeding cuts** did you get from this accident? _____
If yes, what **bruises** did you get from this accident? _____
4c. Please describe how you felt. ***PLEASE BE SPECIFIC***.
Immediately after the accident: _____
Later that Day Night: _____
Over the next days: _____
4d. Check symptoms apparent **since** the accident:

☐Headache ☐Dizziness ☐Loss of memory ☐Sleeping problems ☐Constipation

☐Neck pain/stiffness ☐Fainting ☐Fatigue ☐ Numb toes ☐Chest pain

☐Mid back pain ☐Ringing in ear ☐Tension ☐Numb fingers ☐Nervousness

☐Low back pain ☐Loss of balance ☐Shortness of breath ☐Cold hands ☐Cold sweats

☐Loss of smell ☐ Irritability ☐Cold feet ☐Anxious ☐Eyes sensitive to light

☐Pain behind eyes ☐Loss of taste ☐Depression ☐Diarrhea ☐Other_____

5. WORK STATUS HISTORY

5a. Occupation: _____Employer: _____

5b. Have you missed time from work? ☐ Yes ☐No
5c. If yes: Full time off work: _____
If yes: Part time off work: _____

5d. ☐Been unable to work since the accident.

6. FIRST DOCTOR/HOSPITAL/CLINIC SEEN

6a. Did you go to seek medical help immediately/soon after the accident? ☐ Yes ☐No

6b. If yes, how did you get there? ☐Someone else drove me ☐Drove own car ☐Ambulance ☐Police
DOCTOR 1/HOSPITAL/CLINIC: _ _____Date of 1st visit: _____

6c. Were you examined? ☐Yes ☐No Were X-rays taken? ☐Yes ☐No

6d. Were you given treatment? ☐Yes ☐No
6e. If yes, what treatment was given to you? _____
What benefits did you receive from the treatment? _____
6f. Date of last treatment: _____

7. SECOND DOCTOR/CLINIC SEEN

7a. DOCTOR 2/CLINIC: _____Date of first visit: _____

7b. Were you examined? ☐Yes☐ No Were X-rays taken? ☐Yes ☐No

7c. Were you given treatment? ☐Yes ☐No
7d.If yes, what treatment was given to you? _____
7e. Date of last treatment: _____

8. THIRD DOCTOR/CLINIC SEEN

8a. DOCTOR 3/CLINIC: _____Date of first visit: _____

8b. Were you examined? ☐Yes ☐No Were X-rays taken? ☐Yes ☐No

8c. Were you given treatment? ☐Yes ☐No
8d. If yes, what treatment was given to you? _____
8e. Date of last treatment: _____

9. PRIOR SIMILAR SYMPTOMS

9a. Did you have any physical complaints **just before the accident?** ☐Yes ☐No
9b. If yes, what physical symptoms did you have **just before the accident**? _____
_____

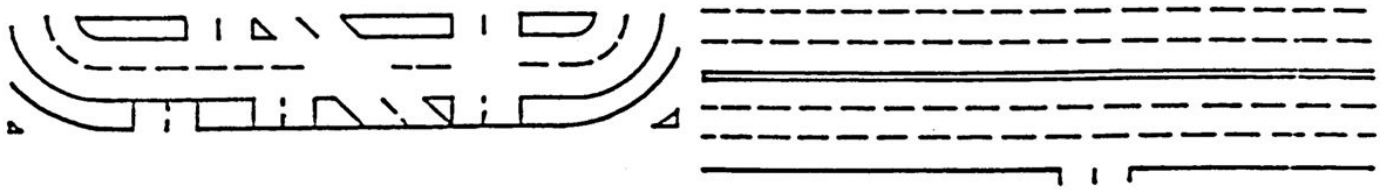
9c. **PRIOR** to this accident, have you **EVER** had symptoms similar to what you're experiencing now? ☐Yes ☐No
9d. If yes, please explain (briefly include past falls, injuries, accidents, operations, etc.):_____
_____

10. ACTIVITES OF DAILY LIVING

10a. Do you notice any of your home activities that are different now than from before the accident? ☐Yes ☐No
10b. If yes, list them as:

- Those activities that you are **now unable** to do are (be specific): _____
- Those activities that are **now painful** to do are (be specific): _____
- Those activities that are **now difficult** to do are (be specific): _____

INDICATE ON THESE DIAGRAMS HOW THE ACCIDENT HAPPENED – (NOTE THE CAR YOU WERE IN AS CAR "A")



ATTORNEY ON CASE

Do you have an attorney on this case? ☐Yes ☐No
If yes, who? Name: _____ Phone: _____
Address: _____ City: _____ State: ____ Zip: _____

AUTOMOBILE ACCIDENT – INSURANCE DATA

Patient's Insurance Company Information – (You)
Company Name: _____ Policy #: _____ Claim#: _____
Address: _____ City: _____ State: ____ Zip: _____
Adjuster's Name: _____ Phone: _____

Insured's Insurance Information – (Driver of car you were in – if not you)
Insured's name if other than you: _____ Phone: _____
Company Name: _____ Policy #: _____ Claim#: _____
Address: _____ City: _____ State: ____ Zip: _____
Adjuster's Name: _____ Phone: _____

Other Driver's Insurance Information – (Other car's driver)
Insured's name if other than you: _____ Phone: _____
Company Name: _____ Policy #: _____ Claim#: _____
Address: _____ City: _____ State: ____ Zip: _____
Adjuster's Name: _____ Phone: _____

Patient Signature: _____ **Date**: _____

Chantilly Chiropractic Center, P.C., 3910 Centreville Rd. #202, Chantilly, VA 20151 (703) 378-2698; Dr. Wm. Todd Fisher; Dr. Gregory Page; Dr. Daniel Robinson