PERSONAL INJURY HISTORY

Name ______________________ Date __________ Phone __________

Address ______________________ City __________ State ______ Zip ______

Age ________ Birthdate ____________ ☐ Male ☐ Female

Date of injury __________ Time __________ A.M./P.M. Where did this injury occur? __________

1. How did your injury happen? ☐ Slip & Fall ☐ Sports Injury ☐ Tripped & Fell ☐ Fell from a ladder or other high place

   ☐ Pedestrian hit by a ______________________

   ☐ Other ______________________

2. Were there any witnesses? ☐ Yes ☐ No If yes, Name ______________________
3. In your own words describe exactly how it happened and what caused it ______________________

   ____

   ____

4. How did you feel immediately after your injury/accident? ______________________

   Later that day? ______________ The next day? ______________

5. Did your pain begin gradually? ☐ Yes ☐ No Immediately? ☐ Yes ☐ No
6. Is your pain? ☐ Continuous ☐ Off and on ☐ Getting better ☐ Getting worse
7. How long have you had this present pain? ________ Hours ________ Days ________ Weeks ________ Months
8. Have you had this or a similar condition before? ☐ Yes ☐ No If yes, when? __________
9. Were you unconscious? ☐ Yes ☐ No If yes, how long? __________
10. Did you receive: ☐ Fractures ☐ Cuts ☐ Bruises ☐ Abrasions Other __________
11. Did you receive medical aid at the time of your injury/accident? ☐ Yes ☐ No If yes, by whom? __________

    ______________ What was done? ______________

12. Where did you go right after your injury/accident? ☐ Hospital ☐ Emergency treatment center ☐ Home ☐ Family physician

    ☐ Resumed activities ☐ Work Other ______________

13. How did you get there? ☐ Ambulance ☐ Drove myself ☐ Walked ☐ Someone drove me
14. If hospitalized how long? __________ Name of hospital __________
15. Have you been treated by any doctor or therapist for this PRESENT injury? ☐ Yes ☐ No If yes, Name __________

    ______________ Where? ______________

16. What type of treatment did you receive? ______________
17. Did the treatments help? ☐ A little ☐ A lot ☐ Made it worse ☐ Stayed the same
18. Prescriptions received: ☐ Pain killers ☐ Muscle relaxants ☐ Antibiotics ☐ Sedatives ☐ Other __________
19. **CHECK ANY SYMPTOMS YOU HAVE NOTICED SINCE YOUR INJURY/ACCIDENT**

☐ Headache	☐ Irritablity	☐ Numbness in Toes	☐ Vomiting	☐ Cold Feet
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatique	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Vision Changes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ ________

20. List any symptoms other than above ______________
21. Have you lost any time off work as a result of this injury? ☐ Yes ☐ No Dates __________
22. Do you have an attorney that has advised you as a result of this injury? ☐ Yes ☐ No If yes, Name __________

    ______________________ Phone __________

Signature of patient ______________________ Date __________

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