Chiropractic Spine Center

Personal Injury History Form

Instructions: Please carefully consider and answer each question as completely as possible.

Name _____ Today's Date (___/___/___) Date of Accident (___/___/___)

If this was an auto accident, were you the ○ Driver ○ Passenger ○ Pedestrian.

If auto collision, were you struck from ○ Behind ○ Right side ○ Left side ○ Front ○ Auto was parked.

○ other _____

Did your car strike the other(s) involved? ○ Yes ○ No. Did the other car strike yours? ○ Yes ○ No.

Were traffic tickets issued? ○ Yes ○ No. If "yes," to ○ You ○ The other driver ○ The driver of your car.

Did any part of your body strike any part of the car? ○ Yes ○ No. If "yes," please explain: _____

_____

Did you have a safety belt on? ○ Yes ○ No. Shoulder strap? ○ Yes ○ No.

Does your car have a headrest? ○ Yes ○ No. Height or Position? ○ Shoulder ○ Neck ○ Head ○ Above.

Loss of consciousness? ○ Yes ○ No. If "yes", please explain: _____

_____

Were you stunned? ○ Yes ○ No. How long? _____

Did you feel or hear popping, tearing, or ripping noise in your neck or back? ○ Yes ○ No. If "yes," please explain: _____

Did you feel any pain? ○ Yes ○ No. If "yes," where? _____

How long after the accident? _____

Did you find any bruises? ○ Yes ○ No. Where: _____

List the extent of injuries as you know them: _____

Instructions: Please check symptoms you have experienced since the accident.

- ○ Headache
- ○ Skull or Head Pain
- ○ Neck Pain
- ○ Neck Stiffness
- ○ Head feels too heavy
- ○ Shoulder Pain
- ○ Shoulder Stiffness
- ○ Arm Pain
- ○ Arm Numbness
- ○ Pins and Needles in Arms
- ○ Numbness in Hands/Fingers
- ○ Cold Hands
- ○ Upper Back Pain
- ○ Upper Back Stiffness
- ○ Mid Back Pain
- ○ Mid Back Stiffness
- ○ Chest Pain
- ○ Rib Pain
- ○ Painful Breathing
- ○ Low Back Pain
- ○ Low Back Stiffness
- ○ Hip Pain
- ○ Buttock Pain
- ○ Leg Pain
- ○ Leg Numbness
- ○ Pins and Needles in Legs
- ○ Numbness in Feet/Toes
- ○ Cold Feet
- ○ Depression
- ○ Anxiety
- ○ Tension
- ○ Irritability
- ○ Nervousness
- ○ Mental Dullness
- ○ Loss of Memory
- ○ Difficulty Sleeping
- ○ Fatigue
- ○ Tremors
- ○ Face Flushed
- ○ Loss of color
- ○ Dizziness
- ○ Fainting
- ○ Sinus Trouble
- ○ Loss of smell
- ○ Eye Strain
- ○ Difficulty Focusing
- ○ Pain Behind the Eyes
- ○ Eyes Sensitive to Light
- ○ Double Vision
- ○ Buzzing or Ringing in Ears
- ○ Loss of Balance
- ○ Palpitations
- ○ Shortness of Breath
- ○ Digestive Problems
- ○ Nausea
- ○ Vomiting
- ○ Diarrhea
- ○ Constipation
- ○ Excessive Perspiration
- ○ Loss of Perspiration
- ○ Loss of Taste
- ○ Cold Sweats
- ○ Fever
- ○ Swelling, if so, where:
- ○ Difficulty in:
  - ○ Prolonged
  - ○ Excessive
    - ○ Riding in car
    - ○ Bending
    - ○ Standing
    - ○ Sitting
    - ○ Walking
    - ○ Lifting
    - ○ Twisting/ turning
- ○ Difficulty rising to walk
- ○ Pain doing occupation

Did you require post accident care or hospitalization? ○ Yes ○ No. If "yes," where? _____

_____ Were you examined? ○ Yes ○ No. If "yes," by whom? _____

Were you x-rayed? ○ Yes ○ No. Was any treatment given? (medication, supports or recommendations):

_____

What is your occupation? _____ What duties are required of you on the job? _____

_____

Have you missed work as a result of this accident? ○ Yes ○ No. If "yes," how many days? _____

Insurance Companies

Your Insurance Company _____ Ins. Adjustor Name: _____

Address _____ City _____ St. __ Zip _____ Phone _____

Insurance of person responsible for the accident? _____ Ins. Adjustor Name: _____

Address _____ City _____ St. __ Zip _____ Phone _____

Your Attorney

Your Attorney's Firm: _____ Attorney Name: _____

Address _____ City _____ St. __ Zip _____ Phone _____

_____