PERSONAL INJURY CONSULTATION

Date of Accident: ______ **Time:** ______ **(A.M.)(P.M.)** **Weather:** ______ **Road Conditions:** ______

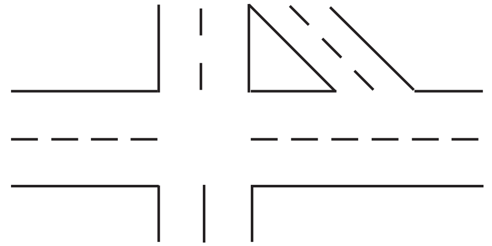
Street(s): ______ Street(s): ______

Patient Headed (N S E W) Other(s) Headed (N S E W)

Patient Speed: ______ Other(s) Speed: ______

Patient Car Type: ______ Other(s) Car Type: ______

Patient Car Hit: ______ Other(s) Car Hit: ______



IMPACT

Body: (Straight/Bent/Twisted)(Left/Right) **Head:** (Neutral/Up/Down)(Rt/Lft) **Braking:** (On/Off) **Patient Awareness**: (None/Partial/Very)

IMMEDIATE POST IMPACT

FIRST AID

Passenger(s) / Passer(s) By / Police / Aid Car / Ambulance / Hospital / Clinic / Home Care

Name: ______ Location: ______ Assistance: ______

Comments: ______

Name: ______ Location: ______ Assistance: ______

Comments: ______

DOCTOR(S) AND TREATMENT

1. ______ Specialty: ______ Diagnostics: ______

Diagnosis: ______ Treatment: ______ Results: ______

2. ______ Specialty: ______ Diagnostics: ______

Diagnosis: ______ Treatment: ______ Results: ______

3. ______ Specialty: ______ Diagnostics: ______

Diagnosis: ______ Treatment: ______ Results: ______

CURRENT DISABILITIES AND RESTRICTIONS

Home: ______

Work: ______

Play: ______

CURRENT SYMPTOMS

	Symptoms	Onset	Frequency	Duration	Intensity	Prior
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						

PREVIOUS INJURIES/ACCIDENTS