

PERSONAL INJURY HISTORY

Name _____ Date _____

Date of Injury _____ Time of Injury _____ A.M. P.M.

1. How did your injury happen?

- Slip and fall Sports Injury Tripped and fell
 Fell from a ladder or other high place
 Pedestrian hit by _____
 Other _____

2. Were there any witnesses? Yes No If yes, name _____

3. In your own words, describe exactly how the accident happened and what caused it.

4. How did you feel immediately after the injury? _____

Later that day? _____

The next day? _____

5. Did your pain begin immediately? Yes No Gradually? Yes No

6. Is your pain... Continuous On and off Getting better Getting worse

7. How long has your pain been present? _____ Hours _____ Days _____ Weeks _____ Months

8. Were you knocked unconscious as a result of the accident? Yes No

9. Did you sustain:

- Fractures If yes, where _____
 Cuts If yes, where _____
 Bruises If yes, where _____
 Abrasions If yes, where _____
 Other _____

10. Have you had this pain or a similar condition before? Yes No

If yes, when? _____

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 after your injury/accident?

- Hospital Home Family physician Resumed activities Work
 Other _____

13. How did you get there?

- Ambulance Drove myself Walked Someone drove me

If hospitalized, how long? _____ Name of hospital _____

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PAGE 2

14. Have you been treated by any doctor or therapist for THIS present injury? Yes No
If yes, Name _____ Where _____
15. What type of treatment did you receive? _____
16. Did the treatments help? A little A lot Made it worse Stayed the same
17. Medication prescribed: Pain killers Muscle relaxants Antibiotics Sedatives None
 Other _____
18. Has the pain you are experiencing disrupted your sleep? Yes No
If yes, where is the pain located
 Head Neck Arms Rt. Lt. Hands Rt. Lt.
 Mid back Low back Legs Rt. Lt. Feet Rt. Lt.
19. Have you lost time off work as a result of your injury? Yes No Dates _____
20. Do you have an attorney that has advised you regarding this injury? Yes No
If yes, Name _____ Phone # _____

ADDITIONAL COMMENTS:

Patient's Signature

Date