

PERSONAL INJURY HISTORY

Name _____

Date of injury _____ Time _____ A.M./PM. 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

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head Seems too Heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Vision Changes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> _____ |

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 _____