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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14. Have you been treated by any doctor of 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*