# PERSONAL INJURY - PATIENT DATA FORM - PI/PDF

Name _____ File # _____ Date _____

10 Date of Accident _____ Time _____ (Am/Pm)

Driver of Car _____ Where Were You Seated _____

Who Owns the Car _____ Year and Model of the Car _____

What was the Approximate Damage Done to your Car $_____

_____

10 Visibility at the Time Of the Accident: Poor/Fair/Good/ Other _____

Road Conditions at the Time of Accident: Icy/Rainy and Wet/Clear/Dark _____

Where was Your Car Struck: Right/Left/Rear/Front/Side/Other _____

Type of Accident: __ Head On __ Broas Side-Collision

__ Rear-End Collision __ Front Impact, Rear-ended Car in Front

__ Non-Collision _____

_____

10 Describe in Your Own Words What Happened to you Upon Impact: _____

_____

_____

Did you See the Accident Coming: __ Yes __ No

Did you Brace for Impact: __ Yes __ No

Were Seat Belts Worn: __ Yes __ No

Were Shoulder Harness Worn: __ Yes __ No

20 Does Your Car Have Headrests: __ Yes __ No

30 If Yes, What Position of Those Headrests Compare to your Head Before the Accident:

__ Top of Headrest Even with Bottom of Head

__ Top of Headrest Even with Top of Head

__ Top of Headrest Even with Middle of Neck

40 Was Your Car Braking: __ Yes __ No

50 Was Your Car Moving at the Time of Accident: __ Yes __ No

60 If Yes, How Fast Would You Estimate You Were Going _____ M.P.H. (Estimate)

70 How Fast was the Other Car Traveling _____ M.P.H. (Estimate)

_____

10 Head/Body Position at the Time of Impact:

__ Head Turned Left/Right __ Body Straight in Sitting Position

__ Head Looking Back __ Body Rotated Left/Right

__ Head Straight Forward __ Other _____

20 At the Time of Accident, Recall what Parts of Your Head or Body hit What Parts on the Inside of Your Car_____

30 As a Result of the Accident You Were: __ Rendered Unconscious __ Dazed, Circumstances Vague

__ Other _____

40 Could You Move All Parts of Your Body: __ Yes __ No

50 If No, What Parts and Why _____

60 Were you able to get out of the Car and Walk Unaided: __ Yes __ No

70 If No, Why Not _____

_____

10 Did you get Bleeding Cuts or Bruises: __ Yes __ No

20 If Yes, What Bleeding Cuts did you get From This Accident _____

If Yes, What Bruises did you get From This Accident _____

30 Please Describe How you Felt. Please be Specific. Immediately after the Accident _____

_____

40 Later That _____Day _____Night _____

50 The Next _____Day _____Days _____

OVER

10 Do you Notice any Activities of your Home Daily Routines that are Different Now than from Before the Accident: __ Yes __ No

20 If Yes, List Them as:

30 Those that you are Unable to do (be specific) _____

40 Those that are Painful to do (be specific) _____

50 Those that are difficult to do (be specific) _____

_____

10 On a Scale of 1-5, with 1 being (examinee's quote) "I'm Pain Free and Can Function Quite Well", and 5 being "I'm in Pain All the Time and Cannot Function at all"' where would you Rate Yourself:

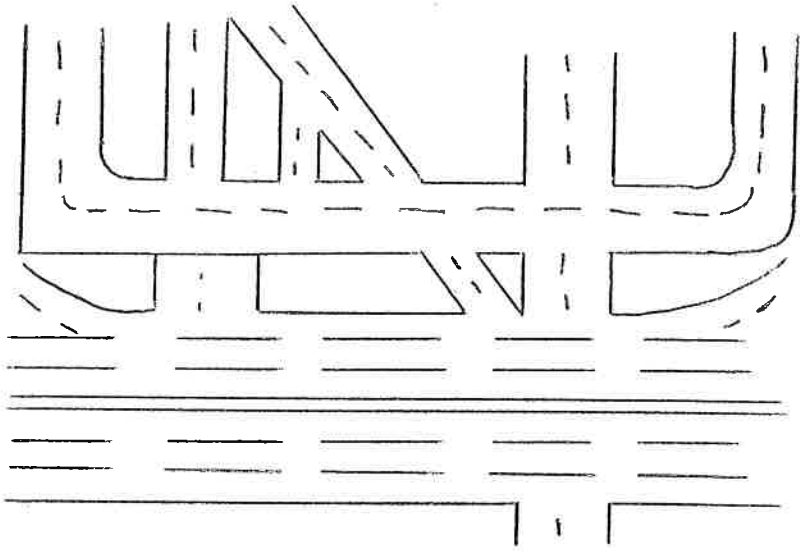
1 2 3 4 5 Please Explain Why _____

_____

20 Relative to Where you were Before this Injury, how Would you rate how Much you have Recovered so Far _____%

_____

Indicate on the diagram
How the Accident Happened



Do you Have an Attorney on This Case: __ Yes __ No If Yes, Who:

Name _____ Address _____ City _____ State ____ Zip ____

_____ _____

Patient Signature Date

AUTOMOBILE ACCIDENT - INSURANCE DATE

Patient's Insurance Company Information:

Company Name _____ PH _____ Policy # _____

P.O. Box/Street # _____ Adjuster's Name _____

City/State/Zip _____

Insured's Insurance Information:

Insured's Name if other than Patient _____ PH _____

Company Name _____ PH _____ Policy # _____

P.O. Box/Street # _____ Adjuster's Name _____

City/State/Zip _____

Other Driver's Insurance Information:

Other Driver's Name (if another Car was involved) _____ PH _____

Company Name _____ PH _____ Policy # _____

P.O. Box/Street # _____ Adjuster's Name _____

City/State/Zip _____

OVER

60 Check Symptoms Apparent Since the Accident:

| | | |
|---|---|---|
| __ Headaches | __ Loss of Smell | __ Numbness On Fingers |
| __ Neck Pain/Stiffness | __ Loss of Taste | __ Cold Hands |
| __ Mid Back Pain | __ Loss of Memory | __ Cold Feet |
| __ Low Back Pain | __ Fatigue | __ Diarrhea |
| __ Eyes Sensitive to Light | __ Tension | __ Constipation |
| __ Pain Behind Eyes | __ Shortness of Breath | __ Chest Pain |
| __ Dizziness | __ Irritability | __ Nervousness |
| __ Fainting | __ Depression | __ Cold Sweats |
| __ Ringing/Buzzing in ears | __Sleeping problems | __ Anxious |
| __ Loss of Balance | __ Numbness in Toes | __ Other _____ |

_____

10 Occupation _____ Employer _____

20 Have you Missed Time From Work: __ Yes __ No

30 If Yes:

40 Full Time Off Work _____ To _____ _____ To _____

50 Part Time Off Work _____ To _____ _____ To _____

60 _____ Been Unable to Work Since the Accident.

_____

10 Did you go to Seek Medical Help Immediately/Soon After the Accident: __ Yes __ No

If Yes, How did you get There: __ Someone else Drove Me __ Ambulance

__ Drove Own Car __ Police

DOCTOR 1/Hospital/Clinic Seen _____ Date of First Visit _____

20 Were you Examined: __ Yes __ No Were you X-Rayed: __ Yes __ No

30 Were you Given Treatment: __ Yes _ No

40 If Yes, What Treatment Was Given To you _____

What Benefits did you Receive From This Treatment _____

50 Date of Last Treatment _____

_____

10 DOCTOR 2/Clinic Seen _____ Date of Second Visit _____

Were you Examined: __ Yes __ No Were you X-Rayed: __ Yes __ No

20 Were you Given Treatment: __ Yes _ No

30 If Yes, What Treatment Was Given To you _____

What Benefits did you Receive From This Treatment _____

40 Date of Last Treatment _____

_____

10 DOCTOR 3/Clinic Seen _____ Date of Second Visit _____

Were you Examined: __ Yes __ No Were you X-Rayed: __ Yes __ No

20 Were you Given Treatment: __ Yes _ No

30 If Yes, What Treatment Was Given To you _____

What Benefits did you Receive From This Treatment _____

40 Date of Last Treatment _____

_____

10 Did you Have any Physical Complaints JUST BEFORE THE ACCIDENT: __ Yes __ No

20 If Yes, Please Describe in Detail _____

30 PRIOR to this Accident, Have you EVER had Symptoms Similar to what you are Experiencing No

__ Yes _No

40 If Yes, Please Explain _____

_____

_____

(Briefly include past falls, injuries, accidents, operations, etc.)