Personal Injury – Patient Data Form

_____ _____ _____ _____

(Name) (Date of Birth) (Age) (Today's Date)

1. Date of the accident: _____ Time: _____AM/ PM
2. Driver of the car: _____ Where were you seated? _____
3. Who owns the car? _____ Year and Model of the car: _____
4. Vehicle damage: Vehicle towed Rollover Under car Totaled Unknown
5. What was the approximate damage done to your car? $_____
6. Visibility at the time of accident: Poor/ Fair/ Good/ Other _____
7. Road conditions at the time of accident: icy/ rainy and wet/ clear/ dark/ other _____
8. Where was your car struck? Right/ Left/ Rear/ Front/ Side _____
9. Type of accident: Head-on collision/ Broad side collision/ Rear end collision/ front impact

   Other: _____
10. Describe in your own words what happened to you upon impact. _____

    _____
11. Did you see the accident coming? Y N
12. Did you brace for impact? Y N
13. Were you wearing a seat belt? Y N
14. Was a shoulder harness worn? Y N
15. Does your car have headrests? Y N
16. If yes, what was the position of those headrests compared 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
17. Was your car moving at the time of accident? Y N
18. What type of vehicle hit you? Make: _____ Model: _____

19. Head/ Body position at time of impact:

Head turned left/ right	Body straight in sitting posture
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 the inside of your car: _____

_____

21. As a result of the accident were you:
Rendered unconscious Dazed, circumstances vague Other: _____
22. Could you move all the parts of your body? Yes No If no, what parts and why: _____

_____

23. Were you able to get out of the car and move unaided? Yes No If no, why not: _____

_____

24. What bleeding cuts did you get from this accident? _____

25. What bruises did you get from this accident? _____

26. Please describe how you felt. Please be specific.

Immediately _____

Later that day: _____ night: _____

The next day: _____ night: _____

27. Check the symptoms that are apparent since the accident

Headache	Loss of smell	Numbness in the 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	Constipation	Dizziness
Pain behind eyes	Shortness of breath	Chest pain
Loss of balance	Numbness in toes	Fainting

Depression Cold sweats Ringing/ buzzing ears
Sleeping problems Other: _____

28. Occupation: _____ Employer: _____

29. Have you missed time from work due to this accident? Yes No Full time Part time

If yes, what were the dates missed? _____

30. Did you seek medical attention immediately/ soon after the accident? Yes No

If yes, how did you get there? Drove own car Ambulance Police Other_____

31. DOCTOR/ HOSPITAL/ CLINIC seen: _____ Date: _____

Were you examined? Yes No Were x-rays taken? Yes No

Of what body parts? _____

What treatment was given to you? Bed rest Brace Physiotherapy
Adjustments Drugs Other_____

What benefits did you receive from treatment? _____
Date of last treatment: _____

32. DOCTOR/ HOSPITAL/ CLINIC seen: _____ Date: _____

Were you examined? Yes No Were x-rays taken? Yes No

Of what body parts? _____

What treatment was given to you? Bed rest Brace Physiotherapy
Adjustments Drugs Other_____

What benefits did you receive from treatment? _____
Date of last treatment: _____

33. Other health care providers: _____

34. Did you have any physical complaints JUST BEFORE THE ACCIDENT? Yes No

If yes, Please describe in detail: _____

_____

35. PRIOR to this accident, have you EVER had symptoms similar to what you're experiencing now? Yes No

If yes, please explain: _____

36. Do you notice any activities of your daily routine that are different from BEFORE the accident? Yes No

Those you are unable to do: _____

Those that are PAINFUL to do: _____

Those that are DIFFICULT to do: _____

37. Do you have an attorney on this case? Yes No

Name: _____ Phone: _____

_____ _____

Signature Date

Personal Injury Insurance information:

_____ _____

(Name) (Date of Birth)

Claim # _____ Claim Rep _____

Policy # _____ DOI: _____

Insurance Phone : _____

Insurance address:

_____

_____

_____

_____