Injury History Form

Patient's name: ___________________________
Today's date: ___________________________
Date of injury: ___________________________

▪What state did the accident occur in? __________
▪What city did the accident occur in? ___________
▪What street or intersection were you on when the accident occurred? ___________________________

▪You were:
☐Driver ☐Front seat passenger
☐Rear seat passenger ☐Motorcycle operator
☐Motorcycle passenger ☐Other ________________

▪The vehicle you were in:
☐ Subcompact ☐ Compact ☐ Mid Size ☐ Full Size
☐ Truck ☐ SUV ☐ Mini Van ☐ Van
☐ Other: ___________________________

▪Your estimated speed at moment of crash: ____mph
☐Stopped ☐Slowing ☐Accelerating

▪Type of vehicle(s) that impacted your vehicle:
☐ Subcompact ☐ Compact ☐ Mid Size ☐ Full Size
☐ Truck ☐ SUV ☐ Mini Van ☐ Van
☐ Other: ___________________________

▪ Number of Vehicles involved? _______________
▪ Estimated speed of other vehicle: ______mph
☐Slowing Down ☐Gaining Speed
☐Stopped ☐Moving at steady Speed

▪Head restraints:
☐None ☐Movable/Adjustable ☐ Non movable
☐Don't know

▪If adjustable, how was headrest positioned on head?
☐Headrest at top of head ☐ Headrest at middle of head
☐ Headrest at back of neck ☐ Headrest level of shoulder

▪Lap belt: ☐Wearing ☐Not wearing ☐None
☐Don't know

▪Shoulder belt:☐Wearing ☐Not wearing ☐None
☐Don't know

▪Body position at time of impact:
☐Straight ☐Forward lean ☐Turned(R or L)
☐Other___________________________

▪Head position at time of impact:
☐Forward ☐Turned Left ☐Turned Right
☐Looking Up ☐Looking Down

▪Hands:
☐One on wheel ☐Two on wheel ☐N/A

▪Aware of impending crash? ☐Yes ☐No
▪Did you brace for the crash? ☐Yes ☐No

▪Crash description: ___________________________
____
____
____
____

Primary impact to your vehicle:
☐Rear ended ☐Your vehicle rear-ended another vehicle
☐Hit on drivers side ☐Hit on passengers side
☐Other (explain): ___________________________
____
____

▪During and after the crash what happened to your vehicle? (check all that apply)
☐kept going straight ☐spun around
☐was hit by another vehicle ☐hit a tree
☐kept going straight hitting a car in front
☐spun around and hit a stationary object
☐ Hit guard rail ☐Vehicle rolled over
☐ Vehicle went into ditch

▪Did your face hit anything? ☐ N/A
☐ Windshield ☐ Steering Wheel ☐ Side Door
☐ Dashboard ☐ Ceiling ☐ Car Frame
☐ Another Passenger ☐ Seat ☐ Side Window
☐ Other: ___________________________

▪Did your neck hit anything? ☐ N/A
☐ Windshield ☐ Steering Wheel ☐ Side Door
☐ Dashboard ☐ Ceiling ☐ Car Frame
☐ Another Passenger ☐ Seat ☐ Side Window
☐ Other: ___________________________

▪Did your chest hit anything? ☐ N/A
☐ Windshield ☐ Steering Wheel ☐ Side Door
☐ Dashboard ☐ Ceiling ☐ Car Frame
☐ Another Passenger ☐ Seat ☐ Side Window
☐ Other: ___________________________

▪Did your knees hit anything? ☐ N/A
☐ Windshield ☐ Steering Wheel ☐ Side Door
☐ Dashboard ☐ Ceiling ☐ Car Frame
☐ Another Passenger ☐ Seat ☐ Side Window
☐ Other: ___________________________

▪Did you slide out of your seatbelt during the accident? ☐Yes ☐No

▪What was damaged in/on your vehicle? (check all that apply)
☐Windshield ☐Rear Window ☐Trunk
☐Steering Wheel ☐Mirror ☐Front Lt.Door
☐Dashboard ☐Knee Bolster ☐Front Rt. Door
☐Seat Frame ☐Rear Bumper ☐Back Lt. Door
☐Side Window ☐ Front Bumper ☐Back Rt. Door
☐Completely totaled ☐ Other: ___________________

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▪Did you lose consciousness? ☐Yes ☐No
If yes, for how long? ______________________________

▪Estimated damage to your vehicle (Cost if known):
$_______Dollars
☐None ☐Minimal ☐Moderate ☐Major

▪Where did you go after the crash?
☐Home ☐Work ☐ Other: _________________
☐Hospital Name: ______________________________
Mode of transportation:☐Ambulance ☐Drove yourself
☐Other______________________________
☐Family Doctor or Convenience Clinic (circle one if applies)
Name: ______________________________

Emergency department (If applies): ☐N/A

▪Radiographs: ☐Yes ☐No
☐X-rays ☐MRIs ☐Special Imaging
Body parts imaged: ______________________
Results: ______________________________

____

▪Cervical Collar? ☐Yes ☐No
▪Back Brace? ☐Yes ☐No
▪Medications Prescribed: ☐ N/A
☐ Pain Medication ☐ Muscle Relaxants
☐ Anti-Inflammatory ☐ Pain Injection
▪Were you admitted overnight? ☐Yes ☐No
▪Any stitches or cuts?: ☐Yes ☐No ______________

▪ Did your head hit anything? ☐ N/A
☐ Windshield ☐ Steering Wheel ☐ Side Door
☐ Dashboard ☐ Ceiling ☐ Car Frame
☐ Another Passenger ☐ Seat ☐ Side Window
☐ Other: ______________________________

▪ Did your shoulders hit anything? ☐ N/A
☐ Windshield ☐ Steering Wheel ☐ Side Door
☐ Dashboard ☐ Ceiling ☐ Car Frame
☐ Another Passenger ☐ Seat ☐ Side Window
☐ Other: ______________________________

▪ Did your hips hit anything? ☐ N/A
☐ Windshield ☐ Steering Wheel ☐ Side Door
☐ Dashboard ☐ Ceiling ☐ Car Frame
☐ Another Passenger ☐ Seat ☐ Side Window
☐ Other: ______________________________

▪ Did your feet hit anything? ☐ N/A
☐ Windshield ☐ Steering Wheel ☐ Side Door
☐ Dashboard ☐ Ceiling ☐ Car Frame
☐ Another Passenger ☐ Seat ☐ Side Window
☐ Other: ______________________________

▪Employment at time of crash:
____
☐Unemployed, Due to crash? ☐Yes ☐No
▪Type of work: ☐Office/clerical ☐Light labor
☐Moderate labor ☐Heavy labor
▪Did you miss work due to your injury?
☐Yes ☐No
Dates missed: From __________to ___________
▪Reason for today's visit:
☐Persistent complaint ☐Worsening of symptoms
☐Other
▪Any prior treatment or injuries to the affected areas before this crash?:
☐Yes, explain below ☐No
____
____
____

Injury History General

▪Time of day:
☐Daylight ☐Dawn ☐Dusk ☐Dark
▪Road conditions:
☐Dry ☐Damp ☐Wet ☐Snow ☐Ice
☐Other ______________________________
▪Was the seat back broken? ☐Yes ☐No
▪Did the air bag deploy? ☐Yes ☐No
If yes, were you struck? ☐Yes ☐No
▪Brake applied? ☐Yes ☐No

During the Crash

▪Wearing a hat or glasses? ☐Yes ☐No
If yes, still on after crash? ☐Yes ☐No
▪If there were lacerations (cuts), where were they?
☐Head ☐Neck ☐Abdomen
☐Upper/Mid back ☐Lower back ☐Pelvis
☐Chest/Rib cage
☐Shoulders (R, L) ☐Arms (R, L) ☐Elbows (R, L)
☐Forearms (R, L) ☐Wrists (R, L) ☐Hands (R, L)
☐Buttocks (R, L) ☐Hips (R, L) ☐Thighs (R, L)
☐Knees (R, L) ☐Legs (R, L) ☐Ankles (R, L)
☐Feet (R, L) ☐Other ________________
▪Did you receive emergency care at the accident site? ☐Yes ☐No
If yes, what type of care?
☐Bandages ☐Splints ☐Brace ☐Neck collar
☐Other ______________________________
☐None ☐Minimal ☐Moderate ☐Major
▪Were the police on-scene? ☐Yes ☐No
If yes, was a report made? ☐Yes ☐No

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After the crash

▪Symptoms you have experienced (check all that apply):

- ☐Headache ☐Dizziness ☐Nausea
- ☐Neck pain ☐Back pain ☐Blurred vision
- ☐Double vision ☐Reduced vision ☐Chest pain
- ☐Palpitations ☐Impaired hearing ☐Constipation
- ☐Diarrhea ☐Vomiting ☐Anxiety
- ☐Tension ☐Frequent urination ☐Depression
- ☐Mood swings ☐Painful urination ☐Nervousness
- ☐Poor memory ☐Convulsions ☐Fatigue
- ☐Restlessness ☐Loss of balance ☐Insomnia
- ☐Weakness ☐Light sensitivity ☐Weight gain
- ☐Weight loss ☐Reduced Appetite ☐Ringing in ears
- ☐Difficulty breathing ☐Confusion/disorientation
- ☐Inability to hold urine
- ☐Numbness/Tingling

If yes, where? ________________________________

▪When did symptoms first appear?

☐Immediately
☐After ______hour(s)after the accident, please clarify which symptoms ____________________________

▪Are you restricted in any of the following areas as a result of the accident?

☐Daily living ☐Occupational/Work
☐Recreational activities ☐Other ________________

▪Did you self-treat your symptoms?

☐Yes ☐No
If yes, please describe: ☐Ice ☐Heat ☐Bed rest
☐Over-the-counter medication
☐Other ____________________________________

Treatment history since the accident

1. Medical Doctor seen:________________________
Specialty:_________________________________
Dates Treatment given: ______________________
Currently treating? ☐Yes ☐No
Special tests done: __________________________
Referred to: _________________________ ☐N/A
Did treatment help? ☐Yes ☐No
Notes: ____
____

2. Medical Doctor seen:________________________
Specialty:_________________________________
Dates Treatment given:______________________
Currently treating? ☐Yes ☐No
Special tests done: __________________________
Referred to: _________________________ ☐N/A
Did treatment help? ☐Yes ☐No
Notes: ____

3. Medical Doctor seen:________________________
Specialty:_________________________________
Dates Treatment given:______________________
Currently treating? ☐Yes ☐No
Special tests done: __________________________
Referred to: _________________________ ☐N/A
Did treatment help? ☐Yes ☐No
Notes: ____
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4. Physical Therapy:__________________________
Performed where:____________________________
Dates of treatment:___________________________
Treatment given: _____________________________
Currently treating? ☐Yes ☐No
Special tests done: __________________________
Referred to: _________________________ ☐N/A
Did treatment help? ☐Yes ☐No
Notes: ____
____

5. Chiropractic Doctor seen:____________________
Dates Treatment given:______________________
Currently treating? ☐Yes ☐No
Special tests done: __________________________
Referred to: _________________________ ☐N/A
Did treatment help? ☐Yes ☐No
Notes: ____
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Any other information regarding this injury?

☐No
☐Yes: ____
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