EUGENE SPINAL CARE

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PERSONAL INJURY PATIENT HISTORY FORM

Name:______________________________________ Date:___________________________

HISTORY OF OCCURRENCE

Date of Accident: ________________________ Time: __________________ AM ( ) PM ( )

Driver of car: ___________________________ Where were you seated:__________________________

Who owns the car: ________________________ Year and model of car: ________________________

What was the approximate damage done to the car you were in? ___________________________________

Visibility at the time of the accident was: ( ) Poor, ( ) Fair, ( ) Good

Road conditions at the time of the accident were: ( ) Icy, ( ) Rainy, ( ) Wet, ( ) Clear, ( ) Dark

Your car: ( ) hit another car, ( ) was hit in the ( ) right, ( ) left, ( ) rear, ( ) front, ( ) side

Type of accident: ( ) Head-on, ( ) Broad-side collision, ( ) rear-end collision,

( ) non-collision (please specify): _____________________________________

IMPACT / SEATBELT / HEADREST / SPEED

Describe in your own words what happened to you upon impact: ___________________________________

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Did you see the accident coming? ( ) Yes, ( ) No

Did you have any warning that the accident was about to happen? ( ) Yes, ( ) No

Did you brace for the impact? ( ) Yes, ( ) No

Were seat belts worn? ( ) Yes, ( ) No

Were shoulder harnesses worn? ( ) Yes, ( ) No

Does your car have headrests? ( ) Yes, ( ) No

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

Was your car braking? ( ) Yes, ( ) No

Was your car moving at the time of the accident? ( ) Yes, ( ) No

If yes, how fast would you estimate you were going? _____________ MPH (please estimate)

How fast was the other vehicle travelling? _________ MPH (Please estimate)

HEAD / BODY POSITION / ABLE TO MOVE BODY

Head/Body position at the time of impact: ( ) head turned, ( ) Right, ( ) Left, ( ) Head looking back

( ) Head straight forward, ( ) Body straight in sitting position, ( ) Body rotated, ( ) Right, ( ) Left

At the time of the accident were you: ( ) Unconscious, ( ) Dazed, circumstances vague, ( ) Shaken up

Could you move all parts of your body? ( ) Yes, ( ) No

If not, what parts and why? ______________________________

Were you able to get out of the car and walk unaided? ( ) Yes, ( ) No

If no, why not? ______________________________

SYMPTOMS FROM ACCIDENT

Did you get bleeding cuts or bruises? ( ) Yes, ( ) No

If yes, what bleeding cuts did you get? ______________________________

If yes, what bruises did you get? ______________________________

Please describe how you felt - Please be specific –

Immediately after the accident: ______________________________

Later that ( ) day, ( ) night ______________________________

Check symptoms apparent since the accident:

( ) Headache ( ) Dizziness ( ) Loss of memory ( ) Sleeping problems

( ) Constipation ( ) Neck pain/stiffness ( ) Fainting ( ) Fatigue

( ) Numbness in toes ( ) Chest pain ( ) Mid-back pain ( ) Ringing/buzzing

( ) Tension ( ) Nervousness ( ) Low back pain ( ) Numbness in fingers

( ) Loss of balance ( ) Cold hands ( ) Cold sweats ( ) Shortness of breath

( ) Eyes sensitive ( ) Loss of smell ( ) Irritability ( ) Cold feet

( ) Anxious ( ) Pain behind eyes ( ) Loss of taste ( ) Depression

( ) Diarrhea ( ) Other: ______________________________

WORK STATUS HISTORY

Occupation: ______________________________

Have you missed time from work? ( ) Yes, ( ) No

If yes, full time off work : __________ to __________ __________ to __________

Part time off work: __________ to __________ __________ to __________

( ) Been unable to work since the accident.

FIRST DOCTOR / HOSPITAL / CLINIC SEEN

Did you go to seek medical help immediately/soon after the accident? ( ) Yes, ( ) No

If yes, how did you get there? ______________________ Date of first visit: __________

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

Were you given treatment? ( ) Yes ( ) No

If yes, what treatment was given to you? ______________________

What benefits did you receive from the treatment? ______________________

Date of last treatment: __________

SECOND DOCTOR / CLINIC SEEN

Whom did you see next? ______________ Date of first visit: __________

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

Were you given treatment? ( ) Yes ( ) No

If yes, what treatment was given to you? ______________________

What benefits did you receive from the treatment? ______________________

Date of last treatment: __________

PRIOR SIMILAR SYMPTOMS

Did you have any physical complaints just before the accident? ( ) Yes ( ) No

If yes, please describe in detail: ______________________

PRIOR to this accident, have you ever had symptoms similar to what you are experiencing now?

( ) Yes ( ) No If yes, please explain (briefly include past falls, injuries, accident, operations, etc.)

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ACTIVITIES OF DAILY LIVING

Do you notice any activities of your home daily routines that are different now than from before the accident?

( ) Yes ( ) No If yes, list them as:

Those activities that you are unable to do are (be specific): ______________________

Those activities that are painful to do are (be specific): ______________________

Those activities that are difficult to do are (be specific): ______________________