

Injury History Form

General Information

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

- Employment:
At time of crash: _____
 Unemployed
- Currently: _____
 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 affected areas:
 Yes, explain below No

Injury History General

- Was the crash on-the-job? Yes No
- 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 _____
- Vehicle driven by: _____
- Your vehicle (year, make, model): _____
- Your estimated speed at moment of crash: _____
 Stopped Slowing Accelerating
- Other vehicle in accident (year, make, model): _____
- Time of day:
 Daylight Dawn Dusk Dark
- Road conditions:
 Dry Damp Wet Snow Ice
 Other _____
- Head restraints:
 None Integral type Adjustable type
 Up Down Don't know

Injury history, General (cont.)

- If adjustable, was the position altered by the crash?
 Yes No
- Was the seat back adjustment altered by the crash?
 Yes No
- Was the seat broken? Yes No
- Lap belt: Wearing Not wearing None
 Don't know
- Shoulder belt: Wearing Not wearing None
 Don't know
- Did the air bag deploy? Yes No
If yes, were you struck? Yes No
- Body position at time of impact:
 Good Forward lean Other _____
- Head position at time of impact:
 Forward Left Right Up Down
- Hands:
 One on wheel Two on wheel N/A
- Brake applied? Yes No
- Aware of impending crash? Yes No
- Did you brace for the crash? Yes No
- Crash description: _____

During the Crash

- Did you strike any parts of the vehicle?
 Yes No
If yes, describe _____
- Did your vehicle strike any objects after crash?
 Yes No
If yes, describe _____
- 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 stationary object
 kept going straight hitting a car in front
 spun around and hit a stationary object

Injury History Form

During the Crash (cont.)

- Did your face hit anything during the accident?
 Yes, _____
 No
- Did your neck hit anything during the accident?
 Yes, _____
 No
- Did you slide out of your seatbelt during the accident? Yes No
- What was damaged in/on your vehicle? (check all that apply)
 Windshield Steering wheel Dashboard
 Seat frame Side window Rear window
 Rear bumper Front bumper Trunk
 Front left door Front right door Back left door
 Mirror Back right door Knee bolster
 Completely totaled
- Choose the item(s) that dented inward:
 floorboards Side door Dashboard
- Choose the doors that would not open as a result of the accident:
 Front left Front right
 Rear left Rear right
- Wearing a hat or glasses? Yes No
If yes, still on after crash? Yes No
- Did you lose consciousness? Yes No
If yes, for how long? _____
- 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 _____
- Estimated damage to your vehicle:
 None Minimal Moderate Major
- Estimated damage to other vehicle:
 None Minimal Moderate Major
- Were the police on-scene? Yes No
If yes, was a report made? Yes No

After the Crash/Injury

- Symptoms you have experienced:
 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? _____
 Extremity pain
If yes, where? _____
- When did symptoms first appear?
 Immediately
 After _____ hour(s) after the accident, please clarify which symptom _____
- Where did you go after the crash?
 Home Work
 Hospital
Mode of transportation: Ambulance
 Other _____
 Private doctor
Doctor's name _____
- 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 _____

Emergency department

- Radiographs: Yes No
 X-rays MRIs Special Imaging
Body parts imaged: _____
Results: _____
- Cervical Collar? Yes No
- Ice? Yes No
- Medications (list): _____
- Other: _____
- Were you admitted? Yes No
- Follow-up instructions: _____
 None

Injury History Form

Treatment history since the accident/injury

1. Dr.: _____
Specialty: _____ Date first seen: _____
Treatment given: _____
Currently treating? Yes No
Special tests done: _____
Referred to: _____ N/A
Did treatment help? Yes No
Notes: _____

2. Dr.: _____
Specialty: _____ Date first seen: _____
Treatment given: _____
Currently treating? Yes No
Special tests done: _____
Referred to: _____ N/A
Did treatment help? Yes No
Notes: _____

3. Dr.: _____
Specialty: _____ Date first seen: _____
Treatment given: _____
Currently treating? Yes No
Special tests done: _____
Referred to: _____ N/A
Did treatment help? Yes No
Notes: _____

4. Dr.: _____
Specialty: _____ Date first seen: _____
Treatment given: _____
Currently treating? Yes No
Special tests done: _____
Referred to: _____ N/A
Did treatment help? Yes No
Notes: _____

5. Dr.: _____
Specialty: _____ Date first seen: _____
Treatment given: _____
Currently treating? Yes No
Special tests done: _____
Referred to: _____ N/A
Did treatment help? Yes No
Notes: _____