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: ______________________________
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