WRITE LEGIBLY

PERSONAL INJURY PATIENT HISTORY

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Name _____ Date _____ File # _____

HISTORY OF OCCURRENCE

Date of Accident:_____ Time:_____ ☐ AM ☐ PM Driver of Car:_____

Where were you seated? ☐ Driver's seat ☐ Front right passenger ☐ Front middle passenger

☐ Rear right passenger ☐ Rear middle passenger ☐ Rear left passenger

Who owns the car?_____ Year and model of car: _____

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

Visibility at time of accident: ☐ Poor ☐ Fair ☐ Good

Road conditions at time of accident: ☐ Icy ☐ Rainy and wet ☐ Clear ☐ Dark

Your car: ☐ Hit another car ☐ Was hit in the: ☐ Right ☐ Left ☐ Rear ☐ Front ☐ Side

Type of accident: ☐ Head–on collision ☐ Broad side–collision

☐ Rear–end collision ☐ Front impact, rear–ended car in front

☐ Non–collision: (Describe)_____

_____

IMPACT/SEAT BELT/HEADREST/SPEED

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

_____

Were you prewarned that the accident was about to happen? ☐ Yes ☐ No

Did you brace for the impact? ☐ Yes ☐ No

Were seat belts/shoulder harness worn? ☐ Yes ☐ No

Does your car have headrests? ☐ No

If yes, what was the position of those headrests compared to your head before the accident?

☐ Top of headrest even with **bottom** of the head ☐ Top of headrest even with **top** of the head

☐ Top of headrest even with **middle** of the neck

Was your car braking? ☐ Yes ☐ No

Was you car moving at the time of accident? ☐ No

If yes, how fast would you estimate you were going? _____MPH (estimate)

How fast was the other car traveling? _____ MPH (estimate) ☐ Don't know

HEAD/BODY POSITION/ABLE TO MOVE BODY

Head/Body position at 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 accident, recall what parts of your **head** or **body** hit what parts on the inside of your car: _____

_____

_____

As a result of the accident you were: ☐ Rendered unconscious ☐ Dazed, circumstances vague

☐ Shaken up but could function

Could you move all parts of your body? ☐ Yes

If no, what body parts could you not move and why? _____

Were you able to get out of the car and walk unaided? ☐ Yes

If no, why couldn't you get out of the car and walk unaided? _____

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SYMPTOMS FROM ACCIDENT

Did you get any bleeding cuts or bruises? ☐ No

If yes, what **bleeding cuts** did you get from this accident? _____

If yes, what **bruises** did you get from this accident? _____

Please describe how you felt. *PLEASE BE SPECIFIC.*

Immediately after the accident: _____

Later that ☐ Day ☐ Night: _____

The next days: _____

Check symptoms apparent **since** the accident:

☐ Headache	☐ Dizziness	☐ Loss of memory	☐ Sleeping problems	☐ Constipation
☐ Neck pain/stiffness	☐ Fainting	☐ Fatigue	☐ Numb toes	☐ Chest pain
☐ Midback pain	☐ Ringing in ear	☐ Tension	☐ Numb fingers	☐ Nervousness
☐ Low back pain	☐ Loss of balance	☐ Shortness of breath	☐ Cold hands	☐ Cold sweats
☐ Eyes sensitive to light	☐ Loss of smell	☐ Irritability	☐ Cold feet	☐ Anxious
☐ Pain behind eyes	☐ Loss of taste	☐ Depression	☐ Diarrhea	

WORK STATUS HISTORY

Occupation: _____ Employer: _____

Have you missed time from work? ☐ No

If yes: Full time off work: _____

If yes: Part time off work: _____

☐ Been unable to work since the accident.

FIRST DOCTOR/HOSPITAL/CLINIC SEEN

Did you go to seek medical help immediately/soon after the accident? ☐ No

If yes, who did you first get treatment from? DOCTOR 1/HOSPITAL/CLINIC SEEN: _____

_____ Date of first visit: _____

Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

Were you given treatment? ☐ 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

DOCTOR 2/CLINIC SEEN: _____ Date of first visit: _____

Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

Were you given treatment? ☐ No

If yes, what treatment was given to you? _____

What benefits did you receive from the treatment? _____

Date of last treatment: _____

THIRD DOCTOR/CLINIC SEEN

DOCTOR 3/CLINIC SEEN: _____ Date of first visit: _____

Were you examined? ☐ Yes ☐ No Were X-rays taken? ☐ Yes ☐ No

Were you given treatment? ☐ 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?** ☐ No
If yes what physical symptoms did you have **just before the accident?** _____

_____

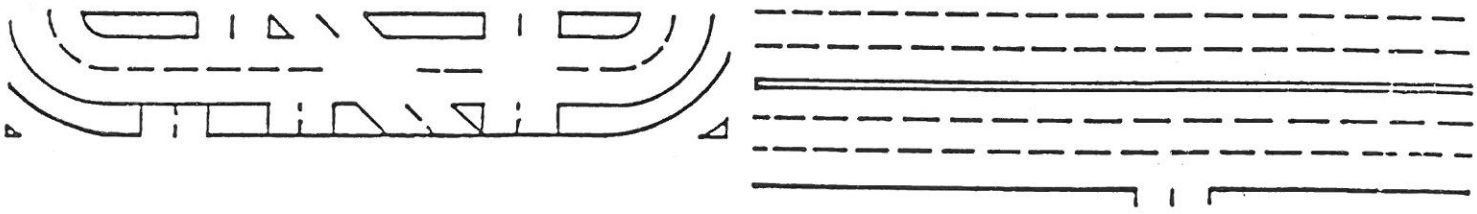
PRIOR to this accident, have you **EVER** had symptoms similar to what you're experiencing now? ☐ No
If yes, please explain (briefly include past falls, injuries, accidents, operations, etc.):

_____

ACTIVITIES OF DAILY LIVING

Do you notice any of your **home** activities that are different **now** than from **before** the accident? ☐ No
If yes, list them as:
Those activities that you are **now unable** to do are (be specific): _____
Those activities that are **now painful** to do are (be specific): _____
Those activities that are **now difficult** to do are (be specific): _____

INDICATE ON THIS DIAGRAM HOW THE ACCIDENT HAPPENED – (NOTE THE CAR YOU WERE IN AS CAR "A")



Patient Signature: _____ Date: _____

AUTOMOBILE ACCIDENT — INSURANCE DATA

Patient's Insurance Company Information – (you)
Company Name: _____ Policy #: _____
Address: _____ City: _____ State: _____ Zip: _____
Adjuster's Name: _____ Phone: _____

Insured's Insurance Information – (Driver of car you were in--if not you)
Insured's name if other than you: _____ Phone: _____
Company Name: _____ Policy #: _____
Address: _____ City: _____ State: _____ Zip: _____
Adjuster's Name: _____ Phone: _____

Other Driver's Insurance Information – (Other car's driver)
Other Driver's Name (if another car was involved): _____ Phone: _____
Company Name: _____ Policy #: _____
Address: _____ City: _____ State: _____ Zip: _____
Adjuster's Name: _____ Phone: _____

KOSAK CHIROPRACTIC

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SUBJECTIVE COMPLAINTS

Patient Name_____ Phone: Home_____ Work_____
Street/PO Box_____ _____Male _____Female Birthdate_____
City/State/Zip_____ Age_____ Height_____ Weight_____lbs
E-Mail Address_____ SS#_____Driver's Lic.#_____
Occupation_____ Emergency Name/Phone#_____

****

DESCRIBE COMPLAINTS: Area(s) of Injury:_____
CHARACTER: ___Pain ___Spasm ___Tender ___Sore ___Ache
(Check all that Apply) ___Shooting ___Weak ___Numb

PAIN LEVEL: On a scale of 0-10, with 0 being you're pain free and can function quite well, and 10 being you're in excruciating pain all the time, where would you rate the intensity of your pain?

0	1	2	3	4	5	6	7	8	9	10
No Pain		Low Pain			Moderate Pain			Intense Pain		Excruciating Pain

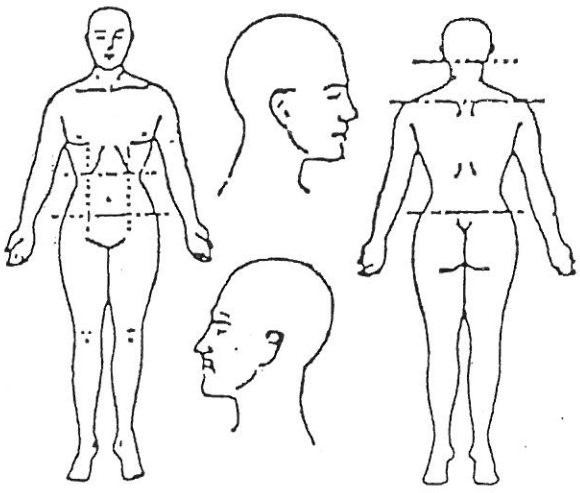
What makes your condition **worse**? ___Nothing ___Lifting ___Trying to stand ___Standing
___Walking ___Sitting ___Movement ___Inactivity ___Work Activities *Other_____

What makes your condition **better**? ___Nothing ___Standing ___Walking ___Sitting ___Movement
___Exercise ___Inactivity ___Lying down ___Sleep ___Hot shower/bath ___Stretching *Other_____

CHECK THE ACTIVITIES THAT CAUSE PAIN/DISCOMFORT:

___Coughing or sneezing
___Getting in or out of a car
___Bending over forward
___Putting on clothes
___Putting on shoes
___Turning over in bed
___Getting out of bed
___Standing for more than 10 minutes
___Standing for more than 60 minutes
___Walking short distances
___Lying flat on stomach
___Lying on side with knees bent
___Climbing
___Kneeling
___Balancing
___Sitting
___Looking back
___Sleeping
___Stooping
___Gripping
___Pushing
___Pulling
___Reaching

SHADE AND CODE AREA(S) OF COMPLAINT
USE CODES: P=PAIN N=NUMB S=SPASM



CHECK YOUR NERVOUS SYSTEM COMPLAINTS:

___Blurring vision
___Buzzing or ringing in ears
___Confusion
___Numbness
___Convulsions
___Depression or crying spells
___Headaches
How often?_____
___Loss of sleep
___Fainting
___Dizziness

Symptoms are **BETTER** in: __AM __Mid-day __PM
Symptoms are **WORSE** in: __AM __Mid-day __PM

(***WOMEN ONLY***) Are you pregnant? Y / N
Date of onset of last menstrual cycle_____

Payment is due at the time of service, unless other arrangements have been made. Patients involved in litigation (law suits) or third party payment are ultimately responsible for payment for services.

****

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT I HAVE READ THE ABOVE AND AGREE TO ABIDE BY SAME.

PATIENT/GUARDIAN SIGNATURE_____ DATE_____