

PERSONAL INJURY - PATIENT HISTORY FORM - PI/PHF

WRITE LEGIBLY

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Name _____ File # _____ Date _____

HISTORY OF OCCURENCEDate 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 time of accident: Poor Fair GoodRoad conditions at time of accident: Icy Rainy and Wet Clear DarkYour 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: _____**IMPACT/SEAT BELT/HEADREST/SPEED**

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

Did you see the accident coming? Yes NoWere you prewarned that the accident was about to happen? Yes NoDid you brace for the impact? Yes NoWere seat belts worn? Yes NoWere shoulder harnesses worn? Yes NoDoes 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 NoWas your car moving at the time of accident? Yes No

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

How fast was the other car travelling? _____ MPH (estimate)

HEAD/BODY POSITION/ABLE TO MOVE BODYHead/Body position at time of impact: Head turned: Right Left Head looking back Head straight forward Body straight in sitting position Body rotated: Right LeftAt 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 functionCould you move all parts of your body? Yes No

If no, what parts and why? _____

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

If no, why not? _____

Name _____ Date _____

SYMPTOMS FROM ACCIDENT

Did you get bleeding cuts or bruises? Yes 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 day(s): _____

Check symptoms apparent since the accident:

- | | | | | |
|--|---|--|--|---------------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Neck pain/stiffness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Midback pain | <input type="checkbox"/> Ringing/buzzing ears | <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Eyes sensitive to light | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Irritability | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Anxious |
| <input type="checkbox"/> Pain behind eyes | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Depression | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Other _____ |

WORK STATUS HISTORY

Occupation: _____ Employer: _____

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 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? Someone else drove me Drove own car Ambulance Police

DOCTOR 1/HOSPITAL/CLINIC SEEN: _____ 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

DOCTOR 2/CLINIC SEEN: _____ 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: _____

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? Yes No

If yes, what treatment was given to you? _____

What benefits did you receive from the treatment? _____

Date of last treatment: _____

Name _____

Date _____

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're experiencing now? Yes No

If yes, please explain (*briefly include past falls, injuries, accidents, operations, etc.*): _____

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*): _____

PAIN LEVEL/SCALE OF RECOVERY

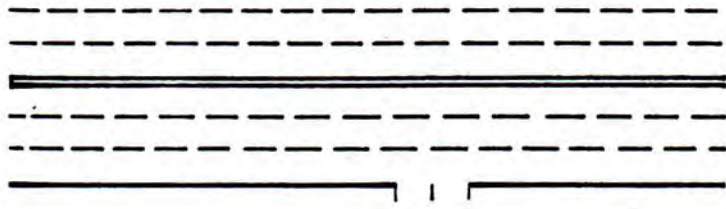
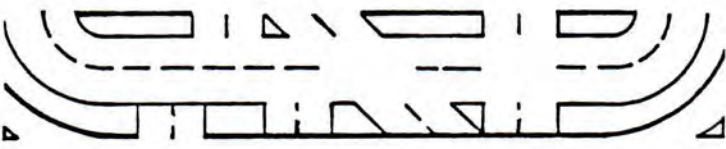
On a scale of 0-10, with 0 being (examiner's quote), "*I'm pain free and can function quite well,*" and 10 being, "*I'm in pain all the time and cannot function at all,*" where would you rate yourself?

NORMAL	LOW PAIN	MODERATE PAIN	INTENSE PAIN	EMERGENCY
0	1 2 3	4 5 6	7 8 9	10

Please explain why: _____

Relative to where you were before this injury, how would you rate how much you have recovered so far? _____ %

INDICATE ON THESE DIAGRAMMS HOW THE ACCIDENT HAPPENED



ATTORNEY ON CASE

Do you have an attorney on this case? Yes No

If yes, who? Name _____

Address _____ City _____ State _____ Zip _____

Patient Signature: _____ Date _____

AUTOMOBILE ACCIDENT — INSURANCE DATA

Patient's Insurance Company Information

Company Name: _____ PH: _____ Policy #: _____

P.O. Box/Street Number: _____ Adjuster's Name: _____

City/State/Zip: _____

Insured's Insurance Information

Insured's name if other than patient: _____ PH: _____

Company Name: _____ PH: _____ Policy #: _____

P.O. Box/Street Number: _____ Adjuster's Name: _____

City/State/Zip: _____

Other Driver's Insurance Information

Other Driver's Name (if another car was involved): _____ PH: _____

Company Name: _____ PH: _____ Policy #: _____

P.O. Box/Street Number: _____ Adjuster's Name: _____

NECK DISABILITY INDEX

Name _____ Date _____ / _____ / _____ File # _____
(Please Print)

This questionnaire helps us to understand how much your neck pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

SECTION 2 - Personal Care (Washing, Dressing etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

SECTION 4 - Reading

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

SECTION 5 - Headaches

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

SECTION 6 - Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

SECTION 7 - Work

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

SECTION 8 - Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I can't drive my car at all.

SECTION 9 - Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr. sleepless).
- My sleep is mildly disturbed (1-2 hrs. sleepless).
- My sleep is moderately disturbed (2-3 hrs. sleepless).
- My sleep is greatly disturbed (3-5 hrs. sleepless).
- My sleep is completely disturbed (5-7 hrs. sleepless).

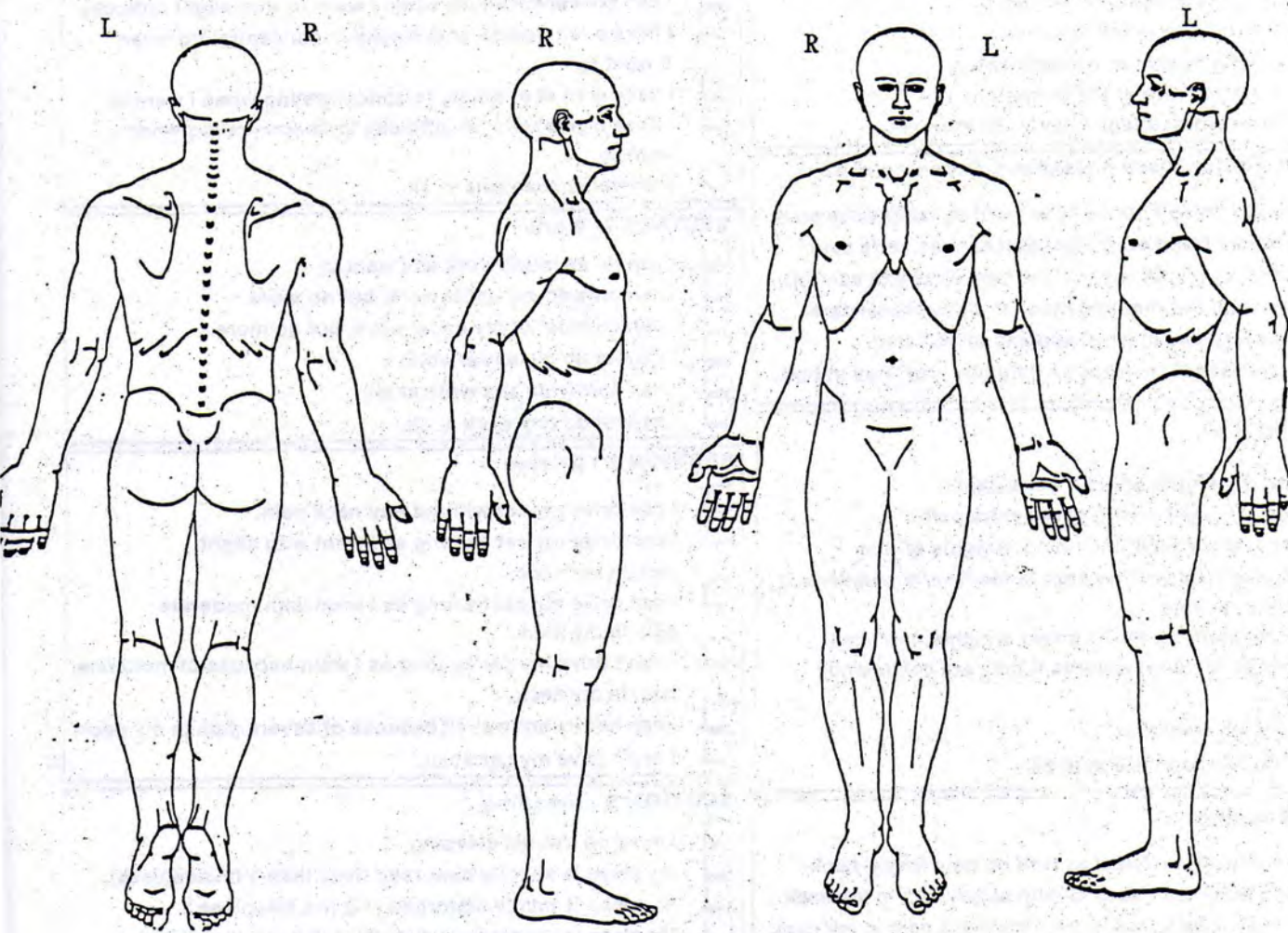
SECTION 10 - Recreation

- I am able to engage in all my recreation activities with no neck pain at all.
- I am able to engage in all my recreation activities, with some pain in my neck.
- I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- I am able to engage in a few of my usual recreation activities because of pain in my neck.
- I can hardly do any recreation activities because of pain in my neck.
- I can't do any recreation activities at all.

Patient Name: _____ Date: _____

Please mark the location and description of your pain according to the following condition:

XX = Sharp/Stabbing √ = Numbness/Tingling O = Ache B = Burning



Pain Scale:

Rate the Severity of your pain by circling one of the numbers on the following scale

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

REVISED OSWESTRY DISABILITY

Name _____ Date ____/____/____ File # _____

(Please Print)

This questionnaire helps us to understand how much your low back pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increase the pain, but I manage not to change my way of doing it.
- Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

SECTION 4 - Walking

- I have no pain on walking.
- I have some pain on walking but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than 1/2 mile without increasing pain.
- I cannot walk more than 1/4 mile without increasing pain.
- I cannot walk at all without increasing pain.

SECTION 5 - Sitting

- I can sit in any chair as long as I like without pain.
- I can sit only in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than 1/2 hour.
- Pain prevents me from sitting for more than 10 minutes.
- I avoid sitting because it increases pain immediately.

SECTION 6 - Standing

- I can stand as long as I want without pain.
- I have some pain on standing, but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than 1/2 hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing, because it increases the pain immediately.

SECTION 7 - Sleeping

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain, my normal night's sleep is reduced by less than 1/4.
- Because of pain, my normal night's sleep is reduced by less than 1/2.
- Because of pain, my normal night's sleep is reduced by less than 3/4.
- Pain prevents me from sleeping at all.

SECTION 8 - Social Life

- My social life is normal and gives me no pain.
- My social life is normal, but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

SECTION 9 - Traveling

- I get no pain while traveling.
- I get some pain while traveling, but none of my usual forms of travel make it any worse.
- I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates, but overall is definitely getting better.
- My pain seems to be getting better, but improvement is slow.
- My pain is neither getting better nor getting worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.