PERSONAL INJURY HISTORY

Date_________________

Patient_______________________________ Phone (   )____-______________

Address_________________________________City_________________State______Zip_________

Age __________ Birthday_______________________ Sex __________S/S#_____________________

Name of Insurance Company: ______________________________Phone# (   )_________________

Address of Insurance Company:____

Case number: ___________________________________Adjuster's name: ______________________

1. Date injured __________Hour __________AM/PM
2. Injured at: ____________________________City _____________ State _________ Zip ________
3. Were you hurt while on the job? ( ) Yes ( ) No
4. In your own words, please describe accident: ____
   ____
   ____
   ____
5. Have you been treated by another doctor for this accident? ( ) Yes ( ) No
   If yes, please list doctor's name and address: ____
   ____
6. What type of treatment did you receive? ____
7. How long were you treated by this doctor? ____
8. Are you: ( ) Improved ( ) Unchanged ( ) Getting Worse
9. What types of medicines are you taking? ____
   ____
   Do those medicines help? ( ) Yes ( ) No ( ) Don't Know
11. Have you had physical therapy? ( ) Yes ( ) No If yes, how often?
   ( ) Daily ( ) Every other day ( ) Several times a week ( ) Weekly ( ) Every other week
   ( ) Monthly ( ) Other ____
   Does the physical therapy help? ( ) Yes ( ) No ( ) Know
12. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?
   ( ) Yes ( ) No
   If yes, describe: ____
   ____
   ____
   Were these similar complaints the results of a previous accident(s)? ( ) Yes ( ) No
   Please provide details of the accident(s): ____
   ____
   ____

13. Have you had any other serious accidents which required medical care? ( ) Yes ( ) No
Describe: ____

14. Have you had any serious illnesses that required hospitalization? ( ) Yes ( ) No
Describe: ____
____

15. Have you had any surgeries? ( ) Yes ( ) No
If yes, list type of surgery and date: ____
____
____

16. Have you had any nervous or mental illnesses? ( ) Yes ( ) No
Have you had psychiatric care? ( ) Yes ( ) No

17. Have you received a medical discharge from the Armed Forces? ( ) Yes ( ) No

18. Have you returned to work since this accident? ( ) Yes ( ) No

CURRENT MEDICAL COMPLAINTS

BACK PAIN:

1.	Currently, I have pain in my:	( ) low back	( ) mid back	( ) upper back
2.	My pain began:	( ) gradually	( ) suddenly	
3.	I have pain:	( ) sometimes	( ) all the time	
4.	My pain goes into my:	( ) right leg	( ) left leg	( ) both
5.	I have tingling and/or numbness in my:	( ) right leg	( ) left leg	( ) both
6.	My pain is worse when I:			
	cough or sneeze	( ) Yes	( ) No	
	sit	( ) Yes	( ) No	
	bend	( ) Yes	( ) No	
	walk	( ) Yes	( ) No	
	lift	( ) Yes	( ) No	
	push	( ) Yes	( ) No	
	pull	( ) Yes	( ) No	
7.	My back is worse with sexual activity	( ) Yes	( ) No	
8.	My pain wakes me up during the night	( ) Yes	( ) No	
9.	Changes in the weather affect my pain	( ) Yes	( ) No	