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	