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Personal Injury Questionaire Form

Patient Name: _____ Exam Date: _____ Injury Date: _____
Age: _____ Employer Name: _____ Occupation: _____

Part of body injured: _____

HISTORY OF ACCIDENT

Describe how the accident occurred:

_____

_____

_____

If this was a car accident please answer the following:

	Yes	No		Yes	No
Were you wearing your seat belt?	☐	☐	Was your car totaled?	☐	☐
Did airbags deploy?	☐	☐	If not, was it driveable?	☐	☐
Did you hit your head?	☐	☐	Did ambulance take you to hospital?	☐	☐
Did you lose consciousness?	☐	☐	Were x-rays taken?	☐	☐

Immediately following the injury, what part (s) of your body hurt? _____

In chronological order, please list the names and specialities of doctors who have treated you for your injury. Then, list the type of treatment which that physician provided to you:

	Name of Doctor	Specialty	Referred by	Date first seen
#1.	_____	_____	_____	_____
	Treatment:	_____		
		_____		
#2.	_____	_____	_____	_____
	Treatment:	_____		
		_____		
#3.	_____	_____	_____	_____
	Treatment:	_____		

PRESENT TREATMENT PROGRAM

Please give the name of the last doctor who saw you: _____

What type of treatment have you been given: _____

MEDICATIONS (Please list all medications, even those not related to your injury).

Name	How often do you take
_____	_____
_____	_____
_____	_____

PRESENT COMPLAINTS AND SYMPTOMS

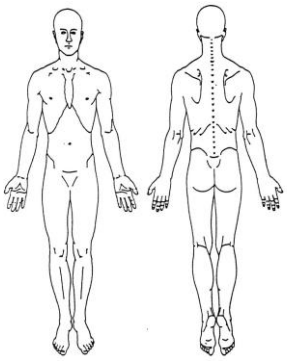
Please describe your symptoms for each injured body part: add additional comments at bottom.

	Body part #1	**Body part #2**	**Body part #3**
Frequency (constant, intermittent)	_____	_____	_____
Type of pain (dull, sharp, stabbing)	_____	_____	_____
Radiates to:	_____	_____	_____
Numbness in:	_____	_____	_____
Popping/clicking	_____	_____	_____
Urinary or bowel problems?	_____	_____	_____
What makes it worse?	_____	_____	_____
What makes it better?	_____	_____	_____

Compared to time of injury, are you (please circle): Better Worse Same

Indicate with the following symbols the kind of pain you are having and where it is located.
XXX = sharp pain OOO = dull pain shading = numbness and tingling.

What is your pain level today: 0----------10



WORK HISTORY

Are you currently working? Yes _____ No _____

If not, when did you last work because of your accident: _____

Please list what other problems you are experiencing because of the accident:

_____

_____

PAST MEDICAL HISTORY

Have you had any previous injuries to the body parts that you have injured at this time? If "YES", please give date of injury: _____

Describe what type of treatment you received (medications, x-rays, surgery, etc):

_____

_____

_____

_____

_____

Did you recover fully from this injury? _____Yes _____ No

If "NO": did you receive a permanent disability award: _____ Yes _____ No

If you received permanent work restrictions, what were they: _____

List any childhood illnesses: _____

List any past and current adult illnesses: _____

List any surgeries and give dates: _____

List any Hospitalizations and give dates: _____

_____

ARE YOU ALLERGIC TO ANY FOODS/MEDICATIONS? _____

What is your height? _____ What is your weight? _____

What is the name of your attorney: _____

What is the name of your insurance: _____