

# Injury History Form

## General Information:

Patient's name: \_\_\_\_\_  
Today's date: \_\_\_\_\_  
Date of injury: \_\_\_\_\_  
Marital status:    M        S        W        D

### Habits:

Smoke:  None    Pk/day \_\_\_\_\_ Years \_\_\_\_\_  
Alcohol:  Never     Social     Light  
           Mod.     Heavy

### Employment:

At time of crash: \_\_\_\_\_  
                           Unemployed  
Currently: \_\_\_\_\_  
                           Unemployed  
                          Due to crash?  Yes     No  
Type of work?  Office/clerical  
                           Light Labor  
                           Moderate Labor  
                           Heavy Labor

## Past Medical History:

Surgeries (dates and residuals): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Fractures (dates and residuals): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Serious Illness (dates and residuals): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Worker's Comp. injuries (date, treatment, awards, residuals): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Personal Injuries (date, treatment, awards, residuals): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Sports or other injuries to head, neck, or back: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any prior history of current complaints:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Prior treatment by Chiropractor for these:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## Current Medical History:

Current health problems:  None  
\_\_\_\_\_

Current medications taken:  None  
\_\_\_\_\_

## General injury history:

Was the crash on the job?  Yes     No

You were:

- Driver                     Front seat passenger  
 Rear seat passenger  
 Motorcycle driver  
 Motorcycle passenger         Other

Vehicle driven by: \_\_\_\_\_

Your vehicle (year, make, model): \_\_\_\_\_

Your estimated speed at moment of crash:

stopped     slowing     Accelerating

Other vehicle (year, make, model): \_\_\_\_\_

Time of day:  daylight     dawn

dusk         dark

Road Conditions:  dry     damp     wet  
                           snow     ice     other

Head restraints:  none     internal type

adjustable type:  up     down

don't know

If adjustable, was the position altered by the crash?  Yes     No

Was the seat back adjustment altered by the crash?  Yes     No

Was the seat broken?  Yes     No

Lap belt:  wearing     not wearing  
                           don't know

Shoulder belt:  wearing     not wearing  
                           don't know

Did air bag deploy?  Yes     No

If yes, were you struck?  Yes     No

Body position:  good     forward lean  
                          other \_\_\_\_\_

Head position:  forward     left     up  
                           right     down

general injury history continued

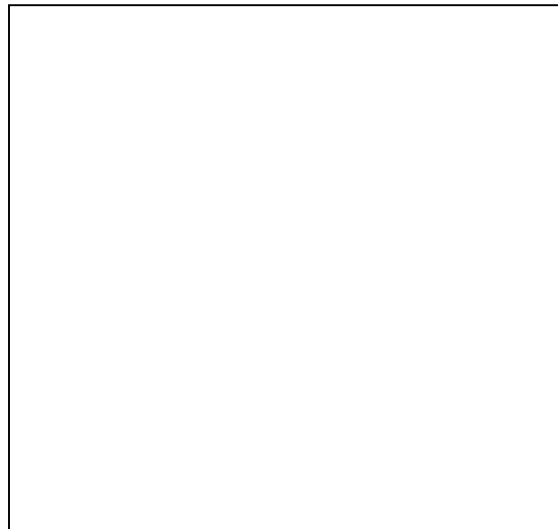
Hands:  one on wheel  two on wheel  
 N/A

Brakes applied?  Yes  No

Crash description: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Crash Diagram:**



Aware of impending crash?  Yes  No

**During the crash:**

Did you strike any parts of the vehicle?  
 Yes  No If yes, describe \_\_\_\_\_

Wearing hat or glasses?  Yes  No

If yes, still on after crash?  Yes  No

Did you lose consciousness?  Yes  No

If yes, for how long? \_\_\_\_\_

Estimated property damage to your vehicle:  
\$ \_\_\_\_\_

Estimated damage to other vehicle(s):  
 none  minimal  moderate  major

Were the police on the scene?  yes  no

If yes, was a report made?  yes  no

**After the crash:**

Symptoms:  headache  dizziness  Nausea  
 confusion/disorientation  
 neck pain  Paresthesia(s)

If yes, where? \_\_\_\_\_

extremity pain. If yes, where? \_\_\_\_\_

back pain

When did symptoms first appear?

immediately, which symptom \_\_\_\_\_

hrs afterward, which symptom \_\_\_\_\_

Where did you go after crash?

home  work  hospital

Mode of transportation \_\_\_\_\_

Doctor \_\_\_\_\_

**Emergency department:**

Radiographs (X-rays):  Yes  No

Body parts imaged \_\_\_\_\_

Results \_\_\_\_\_

Lab work  Yes  No

cervical collar  ice

Medications: \_\_\_\_\_

Other: \_\_\_\_\_

Follow-up instructions :  none \_\_\_\_\_

**Treatment History:**

1. Dr. \_\_\_\_\_

Specialty: \_\_\_\_\_ Date first seen: \_\_\_\_\_

Referred by: \_\_\_\_\_ Treatment type: \_\_\_\_\_

Treatment frequency: \_\_\_\_\_ Treatment duration: \_\_\_\_\_

Currently treating?  Yes  No

Any disability?  Yes  No

If yes, describe: \_\_\_\_\_

Special tests: \_\_\_\_\_

Referred to: \_\_\_\_\_

Did treatment help?  Yes  No

Notes: \_\_\_\_\_

1. Dr. \_\_\_\_\_

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