asha Integrative Wellness

Personal Injury – Patient Data Form

____
(Name) (Date of Birth) (Age) (Today's Date)

1. Date of the accident: _______________ Time: _________________AM/ PM
2. Driver of the car: _______________________ Where were you seated? ______________________________
3. Who owns the car? _____________________ Year and Model of the car: ______________________________
4. Vehicle damage: □Vehicle towed □Rollover □Under care □Totaled □Unknown
5. What was the approximate damage done to your car? $____________________________
6. Visibility at the time of accident: Poor/ Fair/ Good/ Other ____
7. Road conditions at the time of accident: icy/ rainy and wet/ clear/ dark/ other ____________________________
8. Where was your car struck? Right/ Left/ Rear/ Front/ Side ____
9. Type of accident: Head-on collision/ Broad side collision/ Rear end collision/ front impact Other: _______
10. Describe in your own words what happened to you upon impact. ____________________________________

____

11. Did you see the accident coming? Y N
12. Did you brace for impact? Y N
13. Were you wearing a seat belt? Y N
14. Was a shoulder harness worn? Y N
15. Does your car have headrests? Y N
16. 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

17. Was your car moving at the time of accident? Y N
18. What type of vehicle hit you? Make: ____________________ Model: _____________________________

_________________________________ (Name) ________________________ (Date of Birth)

19. Head/ Body position at time of impact:

☐ Head turned left/ right
☐ Head looking back
☐ Head straight forward
☐ Body straight in sitting posture
☐ Body rotated left/ right
☐ Other: ___________________________

20. At the time of accident, recall what parts of your head or body hit the inside of your car: ___________

____

21. As a result of the accident were you: ☐ Unconscious ☐ Dazed ☐ Other: __________________

22. Could you move all the parts of your body? Yes No If no, what parts and why: ___________

____

23. Were you able to get out of the car and move unaided? Yes No

If no, why not: ____

____

24. What bleeding cuts did you get from this accident? ___________________________________

25. What bruises did you get from this accident? ______________________________________

26. Please describe how you felt. Please be specific.

Immediately ____

____

Later that day: _________________________ night: ____________________________

The next day: _________________________ night: ____________________________

____ (Name) _______________________________ (Date of Birth)

27. Check the symptoms that are apparent since the accident

☐ Headache ☐ Loss of smell ☐ Numbness in the fingers
☐ Neck pain/ stiffness ☐ Loss of taste ☐ Cold hands
☐ Mid back pain ☐ Loss of memory ☐ Cold feet
☐ Low back pain ☐ Fatigue ☐ Change in Urinary habits
☐ Eyes sensitive to light ☐ Constipation/ Diarrhea ☐ Dizziness
☐ Pain behind eyes ☐ Shortness of breath ☐ Chest pain
☐ Loss of balance ☐ Numbness in toes ☐ Fainting
☐ Depression ☐ Cold sweats ☐ Ringing/ buzzing ears
☐ Sleeping problems ☐ Other: ________________________

28. Occupation: ___________________________ Employer: ____

29. Have you missed time from work due to this accident? Yes No Full time Part time

If yes, what were the dates missed? ____

30. Did you seek medical attention immediately/ soon after the accident? Yes No

If yes, how did you get there? ☐ Drove own car ☐ Ambulance ☐ Police ☐ Other_________

31. DOCTOR/ HOSPITAL/ CLINIC seen: ________________________________ Date: __________________

Were you examined? Yes No Were x-rays taken? Yes No

Of what body parts? ____

What treatment was given to you? ☐ Bed rest ☐ Brace ☐ Physiotherapy

☐ Adjustments ☐ Drugs ☐ Other__________________________

What benefits did you receive from treatment? ____

Date of last treatment: __________________________

____ (Name) ______________________________ (Date of Birth)

32. DOCTOR/ HOSPITAL/ CLINIC seen: ______________________________ Date: _________________

    Were you examined? Yes No Were x-rays taken? Yes No

    Of what body parts? ____

    What treatment was given to you? ☐ Bed rest ☐ Brace ☐ Physiotherapy

    ☐ Adjustments ☐ Drugs ☐ Other___________________________

    What benefits did you receive from treatment? ____

    Date of last treatment: ___________________________

33. Other health care providers: ____

34. Did you have any physical complaints JUST BEFORE THE ACCIDENT? Yes No

    If yes, Please describe in detail: ____

____

35. PRIOR to this accident, have you EVER had symptoms similar to what you're experiencing now? Yes No

    If yes, please explain: ____

36. Do you notice any activities of your daily routine that are different from BEFORE the accident? Yes No

    Those you are unable to do: ____

    Those that are DIFFICULT or PAINFUL to do: ____

37. Do you have an attorney on this case? YES / NO

    Name: ____Phone: ______________________________

____ _____________________________

Signature **Date**

______________________________ (Name) ______________________________ (Date of Birth)

Patient's Insurance information:

Name of Insurance Provider: ______________________________

Date of Incident (Date of Injury):______________________________

Claim # ______________________________

Claim Rep ______________________________

Policy # ______________________________

Insurance Phone: ______________________________

Insurance address:

____

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Other Party's Insurance Information:

Name of Insurance Company______________________________

(Additional info optional)

Claim Rep ______________________________

Policy # ______________________________

Insurance Phone: ______________________________

Insurance address:

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