**Personal Injury History Form**

Name: Click here to enter patient name. Date: Click here to enter the date.

Date and Time of accident: Click here to enter a date. Click here to enter time. Choose AM/PM.

Location of accident: Location.

Did police come to the scene? [ ] **Yes** [ ] **No**

Is there a police report? [ ]  **Yes** [ ] **No**

Did you go to the hospital? [ ]  **Yes** [ ] **No**

If yes…what is the name of hospital: Hospital.

 Any x-rays, scans, MRI’s or other tests? Tests.

 How did they treat you? Treatment.

 How long did you stay? Length of stay.

 Please describe, to the best of your knowledge, what happened during this accident:

Account of accident.

What bruises, cuts, scrapes did you receive? Click here to enter text.

Did you lose consciousness (black out) after impact? [ ]  **Yes** [ ]  **No**

Did you experience a flash of light or ‘explosion’ in your head? [ ]  **Yes** [ ]  **No**

Did you suffer any of the following symptoms from the accident?

[ ]  **Confused** [ ] **Disoriented** [ ] **Light headed** [ ] **Dizzy** [ ] **Nauseated** [ ] **Blurred vision** [ ] **Ringing/ buzzing ears** [ ] **Changes is bowel or bladder function**

Do you still have any of these symptoms? [ ]  No [ ] Yes If YES, which ones?

Are you currently suffering from any of the following?

[ ]  **Restlessness** [ ] **Irritable** [ ] **Sleeplessness** [ ] **Forgetfulness**

[ ]  **Difficult Concentrating** [ ] **Difficult with Memory** [ ] **Reduced Tolerance to Heat**

[ ] **Reduced Tolerance to Alcohol** [ ] **Headache**

Any other symptoms? Other symptoms.

Anyone else involved? Other Parties.

Do you have an Accident Injury Insurance Policy? [ ] No [ ] Yes

Insurance Co: Company. Policy #: Policy Number.

Local Agent: Agent. Phone #: Phone Number.