**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.