MEYER CHIROPRACTIC CENTER

Personal Injury – Patient History Form

Name_____ Date_____

HISTORY OF OCCURRENCE

Date of Accident_____ Time_____ AM PM

What was the approximate damage done to the car you were in? $_____

Visibility at the time of the accident: ☐Poor ☐Fair ☐Good

Type of accident: ☐Head on Collision ☐Broadside Collision
☐Rear-end Collision ☐Front impact, rear-ended car in front

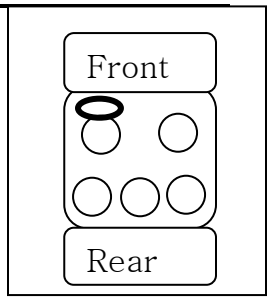
IMPACT / SEAT BELT / SPEED

Describe in your own words what happened to you upon impact:

_____

Where were you seated in the car?_____

Please note in diagram where you were seated in the car at the time of impact:



Did you see the accident coming? Yes No

Did you brace for impact? Yes No

Were seat belts worn? Yes No

How fast would you estimate you were going? _____MPH

What was the position of the 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

HEAD / BODY POSITION / ABLE TO MOVE BODY

Head/Body position at time of impact: ☐Head straight forward ☐ Head looking back

Head turned: ☐Right ☐ Left ☐Body straight in sitting position ☐ Body rotated ☐Right ☐Left

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

_____

_____

Were you able to get out of the car and walk unaided? Yes No If no, why not?_____

SYMPTOMS FROM ACCIDENT

Check symptoms apparent since the accident:

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

WORK STATUS HISTORY

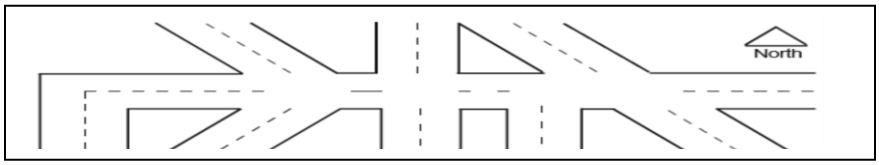
Have you missed time from work? Yes No When?_____

PRIOR SIMILAR SYMPTOMS

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

If Yes, explain. List and give dates:_____

INDICATE ON THE DIAGRAM HOW THE ACCIDENT HAPPENED



ATTORNEY ON CASE

Do you have an attorney on this case? Yes No If yes, who? Name_____

Address, City, State, Zip_____