

# Personal / Home Injury History

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  M  F S.S.#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Insured: \_\_\_\_\_ Address: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_ Telephone #: \_\_\_\_\_

*(If home injury, Home Owner's Policy may be responsible for payment.)*

Have you retained an attorney?  Yes  No Name of Attorney: \_\_\_\_\_

Address of Attorney: \_\_\_\_\_

Date of Accident: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time of Accident: \_\_\_\_\_  A.M.  P.M.

Where did the accident happen? \_\_\_\_\_

Where were you taken after the accident? \_\_\_\_\_

Where did you feel pain? \_\_\_\_\_ Were you unconscious?  Yes  No

What are your present symptoms? \_\_\_\_\_

Are your symptoms:  Improving?  Getting Worse?  Same?  Other? \_\_\_\_\_

Name(s) of any other doctors consulted since your accident: \_\_\_\_\_

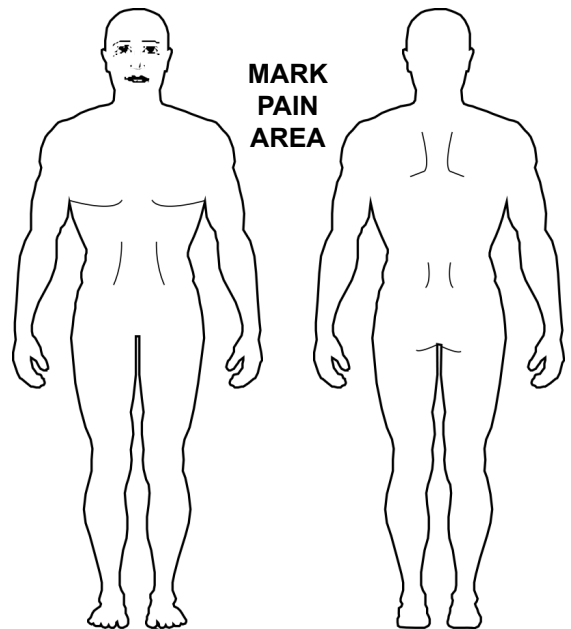
Treatment received: \_\_\_\_\_

How often did you receive treatment from the other doctor? \_\_\_\_\_

Have you previously been injured in a similar manner?  Yes  No

PLEASE EXPLAIN FULLY HOW YOUR ACCIDENT HAPPENED: \_\_\_\_\_

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Date: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

+++ Burning  
--- Sharp  
000 Stabbing  
III Consistent