ACCIDENT HISTORY

Name: ______________________ Age: ________ Date of Birth: ____________ ☐ Male ☐ Female

Date of Accident: ____________ Hour: _____ ☐ AM ☐ PM Location: ______________________

ACCIDENT HISTORY ☐ Auto Injury ☐ Work Injury ☐ Other Injury: ______________________

Please describe the accident in detail: ____

Did anyone witness the accident? ☐ yes ☐ no Did you report the injury to your employer? ☐ yes ☐ no

Were you: ☐ Driver ☐ Passenger ☐ Front seat ☐ Back seat ☐ Pedestrian

Were you struck from: ☐ Behind ☐ Front ☐ Left side ☐ Right side ☐ Vehicle stopped

What direction were you headed: ______________ Name of street you were on: ______________

Did your vehicle strike another vehicle? ☐ yes ☐ no Did their vehicle strike your vehicle? ☐ yes ☐ no

Did the driver of your vehicle get a ticket? ☐ yes ☐ no Did the driver of the other vehicle? ☐ yes ☐ no

Were police notified? ☐ yes ☐ no Did you require hospitalization for these injuries? ☐ yes ☐ no

Have you been treated by a family doctor or E.R. doctor since the accident? ☐ yes ☐ no Please give the name and address of the treating doctor: ____

What type of treatment did you receive? ____

Current Pain Record

☐ A: Sharp ☐ B: Tingling ☐ C: Throbbing ☐ D: Numbness ☐ E: Aching ☐ F: Shooting

☐ G: Dull ☐ H: Burning ☐ I: Cramping ☐ J: Stiffness ☐ K: Swelling ☐ L: __________

3. Please mark your area(s) of pain with the letter (A, B, C etc.) associated with the Type Of Pain you checked above. Indicate the degree of pain by using a scale from 1 (discomfort) to 10 (extreme pain) as seen in the example below:

Example	Show Us Where It Hurts
GGGG 4 FFFF 6	

_______________ Date

_______________ Patient's Signature