PERSONAL HEALTH HISTORY

TO BE COMPLETED BY THE PATIENT

PATIENT'S NAME _____ Today's Date _____ DATE OF BIRTH _____

YOUR Insurance Company _____ Policy # _____

Make/Model/Year of YOUR vehicle _____

If other vehicle involved, name of OTHER (at fault) diver _____

Make/Model/Year of OTHER vehicle _____

OTHER Driver Insurance Company _____ OTHER Policy # _____

(If MedPay) YOUR Claim # _____ **At Fault Insurance Claim #** _____

Do you have Medical Payment Benefits (MedPay) on your policy? ☐ YES ☐ NO ☐ UNSURE

Have you retained an attorney? ☐ YES ☐ NO Name _____

Date of Accident _____ Time of Day _____

Type of Accident ☐ Rear-End Collision ☐ Head-On Collision ☐ Broadside Collision ☐ Non-Collision

Were you the ☐ Driver ☐ Passenger / ☐ Front Seat ☐ Back Seat

Was YOUR vehicle moving at the time of the accident? ☐ YES ☐ NO

How fast would you estimate the OTHER vehicle was traveling? _____

Did you brace for impact? ☐ YES ☐ NO Did your airbag deploy? ☐ YES ☐ NO

Were you wearing your seatbelt? ☐ YES ☐ NO

Did your vehicle have headrests? ☐ YES ☐ NO / If yes, what was the position of your headrest?

Top of Headrest: ☐ even with bottom of head ☐ even with top of head ☐ even with middle of head

Was YOUR vehicle braking? ☐ YES ☐ NO Was the OTHER vehicle braking? ☐ YES ☐ NO

Do you recall striking your head or other body part at impact? ☐ YES ☐ NO Explain _____

Were you taken by ambulance to the hospital? ☐ YES ☐ NO If yes, which hospital? _____

Have you received any other medical attention since the date of accident? ☐ YES ☐ NO

If yes, name of clinic _____ Date(s) _____

✳IMPORTANT PLEASE FILL OUT <u>COMPLETELY</u>

CHECK SYMPTOMS APPARENT <u>SINCE</u> THE ACCIDENT

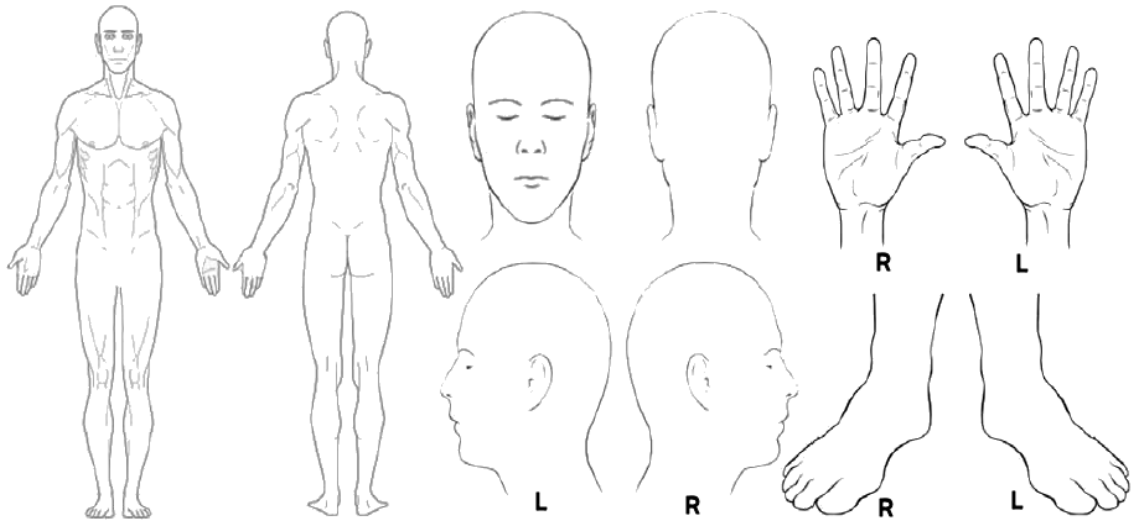
☐ Headache	☐ Visual Disturbance	☐ Irritability	☐ Weakness
☐ Neck Pain	☐ Anxiety/Depression	☐ Forgetfulness	☐ Jaw Pain
☐ Mid Back Pain	☐ Lack of Coordination	☐ Lack of Energy	☐ Shoulder Pain
☐ Low Back Pain	☐ Difficulty with Walking	☐ Constipation	☐ Elbow Pain
☐ Dizziness	☐ Difficulty Concentrating	☐ Diarrhea	☐ Wrist Pain
☐ Sleep Disturbance	☐ Ringing in Ears	☐ Tingling	☐ Ankle Pain

☐ Bruising/Cuts/Scrapes = Location _____

PERSONAL HEALTH HISTORY (PAGE 2)

TO BE COMPLETED BY THE PATIENT

PLEASE MARK ALL AREAS OF COMPLAINT SINCE THE ACCIDENT



MARK: CIRCLE = AREA OF PAIN, X = AREAS OF NUMBNESS,
Z = AREAS OF TINGLING, W = AREAS OF WEAKNESS,
C = BRUISING/CONTUSIONS/ABRASIONS

Did you have any of your current physical complaints BEFORE THE ACCIDENT? ☐ Yes ☐ No

If yes, please explain _____

Have you lost time from work as a result of this accident? ☐ Yes ☐ No

If yes, please complete. Last Day Worked _____

If back to work, dates you missed work _____

Type of Employment _____

Duties at work that you are unable to perform _____

LIST YOUR % WORK ABILITY SINCE THE AUTO ACCIDENT _____ %

(0% = no capacity / unable to work AND 100% = full capacity / normal)

Please list THREE activities of daily living that have been affected since the accident:

(for example: unable to play with kids, unable to drive, unable to do laundry, etc.)

1) _____ 2) _____ 3) _____

LIST YOUR % ABILITY TO PERFORM EACH OF THE ABOVE ACTIVITIES

1) _____ % 2) _____ % 3) _____ % (0% = no capacity / unable to work AND 100% = full capacity / normal)

Auto Accident History completed by:

_____ _____

Parent/Legal Guardian Signature Date

_____

Printed Name