Essence of Life Spinal Care
5811 Memorial Hwy. Suite 106 Tampa, FL 33615 **Phone**: 813-330-0232 **Fax**: 813-345-4075

Personal Injury Accident History Report

Patient Name: _____

Date of Accident:_____ Time of Accident: _____

Where did the accident happen?_____ City _____ State_____

Describe the accident in your own words: _____

_____

_____

_____

_____

What was your position in the vehicle? (Circle) Driver or Passenger

If passenger, were you sitting in: (Circle) Front Right rear Left rear

Did your vehicle strike the other vehicle? (Circle) YES NO

Was the impact from: (Circle) Front Left side Right side Rear

At the time of impact were you: (Circle) Looking straight ahead Looking right Looking left

Were both hands on the steering wheel? YES NO Was your foot on the brake? YES NO

Were you braced for impact? YES NO

Were you wearing a seat belt? YES NO **If yes,** (Circle) Shoulder belt or Lap Belt

Where in the vehicle were you after the accident? _____

Did you strike anything in the vehicle after the impact? YES NO Dazed, cannot remember

If yes, which one(s)? Windshield Headrest Dashboard Steering wheel Back of seat

Door frame Side window Rear view mirror Rear window of pickup Side window

Which part of your body? Chest Chin Head Face Neck Back Hand R L Wrist R L

Arm R L Elbow R L Shoulder R L Leg R L Knee R L Ankle R L Other _____

Immediately after the accident how did you feel? _____

_____

Were you: (Circle) Conscious Unconscious Cut or bleeding In a daze

Did you have: Head pain (headache) Neck pain R L Upper back pain R L Mid back pain R L

Low back pain R L Lower extremity pain R L Upper extremity pain R L

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When did the pain begin? (Circle) Immediately Shortly after Several hours later Several days

List the extent of injuries as you know them: _____

_____

Did you report the accident: YES NO To Whom: _____

Did you go to the hospital? YES NO **When?** At time of accident Next day Other _____

How did you get there: (Circle) Ambulance Private transportation NA

Did the ambulance attendants place you in: (Circle) Neck collar Splints Brace NA

Name of Hospital: _____ Attended by Doctor: _____

Were you X-Rayed at the hospital? YES NO

If so, What was the diagnosis_____

Were you admitted to the hospital? YES NO If so, how long? _____

What treatment was rendered? _____

At hospital did you see: (Circle) Your own Doctor Orthopedic Doctor Physical therapist

Have you seen any other doctor as a result of this accident? YES NO

If yes, Name: _____ Date: _____

If you did not go to the hospital did you: (Circle) Go Home Go to work Go to the doctor

If you went home did you: (Circle) Go to bed Take it easy Go about normal business

Is your pain: (Circle) Constant On and Off Sharp Dull Other: _____

Is your pain worse:

When rising? Y N When Straining? Y N When Coughing? Y N When Sneezing? Y N

When straining during bowel movements? Y N When stretching or twisting? Y N

With a change in heel height? Y N

What is your most common position? Sitting Standing Lying - Rt side Lt side Back Stomach

Is it difficult for you to move around in bed? YES NO

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Do you have: A firm mattress? YES NO A cervical pillow? YES NO

Does any of the following relieve your pain? Heating pad Hot bath Shower Ice pack Brace

Do you feel better: (Circle) Moving around Resting

Do your knees ache or hurt? YES NO

Circle the symptoms you have noticed since the accident:

Headache	Irritability	Face flushed	Ear ringing
Neck pin	Chest pain	Light bothers eyes	Buzzing in ears
Neck stiffness	Dizziness	Shortness of breath	Loss of memory
Muscle tension	Fever	Numbness in toes	Cold sweats
Back pain	Fatigue	Numbness in fingers	Fainting spells
Nervousness	Depression	Pins & needles in arms	Loss of smell
Loss of balance	Cold feet	Pins & needles in legs	Loss of taste
Upset stomach	Cold hands	Head seems too heavy	Leg cramps
Diarrhea	Constipation	Change in bowel habits	

Have you had similar symptoms prior to this accident? YES NO

If yes, which ones? _____

Did you enjoy good health prior to this accident? YES NO

If no, please explain:_____

Have you had any previous accidents? YES NO

If yes, please describe:_____

Have you lost any time from work because of this accident? YES NO How much? _____

Are you currently working? Y N (circle) Full time Part time Impaired function Normal function

Are you working with an attorney? YES NO Name _____

Address _____

Phone number _____

Patient Signature _____Date:_____