INNOVATIVE Health
Chiropractic • Laser Therapy
Functional Medicine
2114 Schofield Avenue • Weston, WI 54476

PERSONAL INJURY SUPPLEMENT

A supplement to the Patient Health History form for personal injury cases .

Legal Name (*First, Middle, Last*): | Date of Birth:

Date of Accident: Time of Day: ☐ AM ☐ PM

Where did the accident occur:

Describe what happened in your own words:

What activity (if any) were you engaged in at the time of the accident?

Were you struck by something? ☐ Yes ☐ No If yes, by what?

If you were struck, what part of your body was hit?

Were you: ☐ Sitting ☐ Standing ☐ Lying ☐ Moving If you were moving, describe:

As a result of the accident, were you: ☐ Rendered unconscious ☐ Dazed, details are vague ☐ Shaken up, but able to function

Could you move all parts of your body? ☐ Yes ☐ No If no, what parts and why not?

Were you able to get up and walk unaided? ☐ Yes ☐ No If no, why not?

WORK STATUS

Occupation: | Employer:

What type of physical activity is required at work:

Have you missed time from work: ☐ Yes ☐ No If no, who told you to return to work? _____

If yes, choose one: ☐ I have been unable to work since accident

☐ Off work Full Time Dates: _____

☐ Off work Part Time Dates: _____

SYMPTOMS

Did you receive bleeding cuts? ☐ Yes ☐ No If yes, where?

Did you receive bruises? ☐ Yes ☐ No If yes, where?

Please describe how you felt in the timeframes noted below. Please be as specific as you can.

Immediately after the accident: _____

Later that ☐ day ☐ night: _____

The next day(s): _____

Check all symptoms that have become apparent since the injury:

___ Nervousness
___ Neck pain / stiffness
___ Mid back pain
___ Low back pain
___ Eyes sensitive to light
___ Pain behind eyes
___ Dizziness
___ Cold sweats
___ Face flushed
___ Ringing/buzzing in ears
___ Loss of balance
___ Loss of smell
___ Loss of taste
___ Loss of memory
___ Pins & Needles—Arms
___ Pins & Needles—Legs
___ Shortness of breath
___ Head seems too heavy
___ Irritability
___ Depression
___ Sleeping trouble
___ Toe numbness
___ Finger numbness
___ Cold hands
___ Cold feet
___ Chest pain
___ Constipation
___ Diarrhea
___ Fatigue
___ Tension
___ Fever
___ Headache
___ Fainting
___ Anxiety
___ Seizures
___ Visual Disturbances
___ Blurred Vision
___ Double Vision
___ Forgetfulness
___ Confused
___ Disoriented
___ Other:_____

MECHANISM OF INJURY *Only complete the sections that apply to you.*

☐ **BEND** How far were you bent over? | Were you lifting when you were bent over? ☐ No ☐ Yes

If yes, what were you lifting? | If yes, how much did the object weigh?

Did you fall when the pain started? ☐ No ☐ Yes If yes, how far?

Were you twisting when you were bent forward? If yes, to which side? ☐ Left ☐ Right

MECHANISM OF INJURY CONT'D *Only complete the sections that apply to you.*

☐ **FALL** Did you hit anything when you fell? ☐ No ☐ Yes If yes, what?

Were you carrying anything when you fell? ☐ No ☐ Yes If yes, what?

How much did it weigh?	Did it land on you? ☐ No ☐ Yes
Did you twist when you fell? ☐ No ☐ Yes If yes, to which side? ☐ Left ☐ Right	
What part of your body did you fall on?	How far did you fall? (in feet)
What did you land on?	Was the area lighted? ☐ No ☐ Yes

Describe the condition of the area: (slippery, gravel, wet, etc…)

☐ **LIFT / PULL** At the time of the injury were you ☐ Lifting ☐ Pulling ☐ Both

What were you lifting/pulling?	How much did the object weigh?

Did you fall after the injury? ☐ No ☐ Yes If yes, how far?

Did you hit anything when you fell? ☐ No ☐ Yes If yes, what?

Were you twisting when you were lifting/pulling? ☐ No ☐ Yes If yes, to which side? ☐ Left ☐ Right

How far off of the ground did you have the item before the pain started?

Did you drop the object when the pain started? ☐ No ☐ Yes

Did it land on you? ☐ No ☐ Yes If yes, where?

Did you lift with your ☐ Legs ☐ Back ☐ Other (describe):

FIRST DOCTOR / HOSPITAL / CLINIC Did you seek medical attention after the accident? ☐ No ☐ Yes

If yes, how did you get there? ☐ Ambulance ☐ Police ☐ Someone else drove me ☐ Drove myself

Doctor / Hospital / Clinic:	Date of first visit: Date of last visit:
Where you examined? ☐ No ☐ Yes	Were X-rays taken? ☐ No ☐ Yes

What diagnosis were you given?

Where you treated? ☐ No ☐ Yes If yes, describe:

What benefits did you receive from the treatment?

Were you referred to another provider? ☐ No ☐ Yes If yes, to who? for what?

Did you see the referred provider? ☐ No ☐ Yes If no, why not?

SECOND DOCTOR / HOSPITAL / CLINIC

Doctor / Hospital / Clinic:	Date of first visit: Date of last visit:
Where you examined? ☐ No ☐ Yes	Were X-rays taken? ☐ No ☐ Yes

Where you treated? ☐ No ☐ Yes If yes, describe:

What benefits did you receive from the treatment?

PRIOR SIMILAR SYMPTOMS

Did you have any physical complaints before the accident? ☐ No ☐ Yes If yes, describe in detail:

Prior to this accident, have you ever had similar symptoms? ☐ No ☐ Yes If yes, explain:

Do you have any congenital (birth) factors which relate to this problem? ☐ No ☐ Yes if yes, explain

Additional Comments:

Patient Signature: _____ **Date:** _____

Parent/Guardian/Legal Representative:_____ **Date:** _____

Staff Initials: