PERSONAL INJURY INFORMATION

Texas Injury Clinic

Current Symptoms / Areas of Complaints

Name: _____ **Date your symptoms began:** _____

Symptoms you have experienced since your collision/incident:

- ❑ Neck pain
- ❑ Neck restriction
- ❑ Arm pain ❑ Left ❑ Right
- ❑ Middle back pain
- ❑ Lower back pain
- ❑ Lower back restriction
- ❑ Leg pain ❑ Left ❑ Right
- ❑ Headache
- ❑ Bleeding/Cuts (location) _____
- ❑ Bruising (location)
- ❑ Dazed / Confused
- ❑ Dizziness
- ❑ Nausea / Vomiting
- ❑ Visual disturbances
- ❑ Ringing / Buzzing in ears
- ❑ Activities that increase pain (explain) _____
- ❑ Other symptoms _____
- ❑ Loss of Consciousness ❑ Less than 5 min ❑ Greater than 5 min
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Fatigue
- ❑ Anxiety

- Rate your pain on a scale of 0-10 (0 = No pain, 10 = Severe Pain) 0 1 2 3 4 5 6 7 8 9 10

Since the collision/incident, your pain is? ❑ Same ❑ Getting better ❑ Getting worse

Emergency Care / Previous Treatment

- Did you seek medical attention immediately? ❑ Yes ❑ No ❑ Hospital ❑ Primary Doctor

  If yes, give the name and address of facility: _____
- How did you get there? ❑ Ambulance ❑ Drove myself ❑ Someone else drove me ❑ Other _____
- Were you examined? ❑ Yes ❑ No Doctor and phone #: _____
- Did you receive any of the following? ❑ Medication ❑ Neck collar ❑ X-Rays (areas): _____

  ❑ Stitches ❑ Hospital stay ❑ Surgery ❑ CT or ❑ MRI (areas):

Motor Vehicle Collision Information

Date of Collision: _____ **Make / Model / Year of vehicle:** _____

Estimated damages: $ _____ **Was vehicle towed?** ❑ Yes ❑ No **Police Report?** ❑ Yes ❑ No

- You were the: ❑ Driver ❑ Front passenger ❑ Rear passenger (driver or passenger side?)
- What type of collision? ❑ Head-on ❑ Front impact ❑ Rear impact ❑ Broad-sided (driver or passenger side?)

  ❑ Multiple Impacts – Please describe: _____
- At impact, what was the speed of your vehicle: _____ mph Other vehicle: _____ mph
- Type(s) of restraint: ❑ Lap belt & shoulder harness ❑ Lap belt Only ❑ Child seat ❑ None
- Was your vehicle equipped with airbags? ❑ Yes ❑ No If yes, did your airbag inflate? ❑ Yes ❑ No
- Were you aware of the impending collision? ❑ Yes ❑ No
- Did you brace for impact? ❑ Yes ❑ No If yes, what did you brace with? ❑ Arms ❑ Feet
- What was the position of your head and body at the time of impact?

  ❑ Head straight ❑ Head turned left ❑ Head turned right ❑ Body turned left ❑ Body straight ❑ Body turned right
- Did your body contact the vehicle at impact? ❑ Yes ❑ No If yes, what areas? _____

  If yes, what part of the vehicle did your body contact? ❑ Headrest ❑ Windshield ❑ Side window ❑ Steering wheel ❑ Dashboard ❑ Other _____
- Was your body thrown / jolted by the impact? ❑ Side-to-side ❑ Forward and backward

Other passengers with you, Names and Relationship: _____

BY SIGNING BELOW, I ACKNOWLEDGE THAT THE INFORMATION PROVIDED ABOVE IS BOTH ACCURATE AND COMPLETE.

_____ _____

Signature of Patient / Legal Guardian and Relationship to Patient **Date**

_____

Printed Name of Patient / Legal Guardian