

No-Fault Injury History Form

This form must be completed in its entirety and without omission. Failing to be 100% truthful could be detrimental to your case.

General Information:

Name: _____

Today's Date: ____/____/____

Date of Injury: ____/____/____

Habits:

Smoke: None Pk/day ____ Years ____

Alcohol: None Social Lt Mod Heavy

Employment:

Occupation at time of accident: _____

Unemployed

Current Occupation: _____

Unemployed – Due to accident? Yes No

Type of work: Office/clerical Light Labor

Moderate Labor Heavy Labor

Past Medical History

Surgeries (Describe with dates and residual symptoms):

Fractures (Describe with dates and residual symptoms):

Serious Illness (Describe with dates and residual symptoms):

Work Related Injuries (Describe with dates and residual symptoms):

Personal Injuries (Describe with dates and residual symptoms):

Sports or other injuries to head neck or back:

Past Medical History (Cont'd)

Prior History of Current Complaints: None

1. _____
2. _____
3. _____
4. _____

Prior Treatment for these: None

1. _____
2. _____
3. _____
4. _____

Current Medical History:

Current Health Problems unrelated to accident: None

Current Medications Taken: None

Accident History – General:

Was the accident on-the-job? Yes No

You were: Driver Front Seat Passenger

Rear Seat: L / M / R Motorcycle Operator

Motorcycle passenger Other: _____

If Passenger, vehicle driven by: _____

Your Vehicle (Make, Model, Year): _____

Estimated speed at time of impact: _____

Were you Stopped Slowing Accelerating

Other Vehicle (Make, Model, Year): _____

Time of Day: Dawn Mid-Day Dusk Dark

Conditions: Dry Damp Wet Snow Ice

Other: _____

Head Restraints: None Integral Type (continuation)

Adjustable, Position Up Down Don't Know

If Adjustable, was position altered by the accident?

Yes No Don't Know

Was the seatback adjustment altered by the accident?

Yes No Don't Know

Was the seat broken? Yes No Don't Know

Lap Belt: Wearing Not Wearing Don't recall

Shoulder Belt: None Wearing Not Wearing Don't Recall

Did Air Bag Deploy? Yes No None

If Yes, were you struck/injured? Yes No

Describe: _____

Body Position just prior to impact: Sitting Back

Forward Lean Other: _____

Head Position just prior to impact: Facing Forward

Left Right Up Down

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Accident History, General (cont'd):

At the time of the impact were your hands:

Both on the wheel R/L on the wheel Neither/NA

Were your Brakes applied? Yes No

Describe Accident: _____

Did you have prior warning of accident? Yes No

Accident Diagram:

During the crash:

Did any part of your body strike any part of your vehicle?

No Yes – Describe: _____

Did your vehicle strike any object after the initial impact?

No Yes – Describe: _____

Were you wearing a hat or glasses? No Yes

If yes, were they still on after the crash? No Yes

If not still on, where did they land? _____

Did you lose consciousness? No Yes – How long: _____

Estimate damage to your vehicle: \$ _____

Estimate damage to other vehicle(s): None

Minimal Moderate Major/Totaled

Were the Police on the scene? No Yes

If yes, was a report made? No Yes

After the Crash:

Indicate the symptoms you experienced and when and where you first noticed them: Dizziness _____

Headache _____ Nausea _____

Confusion/Disorientation _____

Neck Pain _____ Back Pain _____

Numbness/Weakness/Tingle _____

Other – Describe _____

Where did you go after the accident? Home

Work Hospital – Name _____

How did you get there? Ambulance Other _____

Hospital Emergency Room (Skip if did not go):

Did you go: Immediately When _____

Were X-Rays taken? No Yes

What Body Parts? _____

What else was done? Lab Work Cervical Collar

Ice Heat Medications – Name _____

Other _____

Admitted Released with instructions: _____

Prior Treatment History (For this Accident):

1. Dr. _____

Specialty: _____ Date 1st seen: ___/___/___

Referred by: _____

Treatment type/Frequency/Duration: _____

Still Treating? No Yes Has it Helped No Yes

Disability: Total: From ___/___/___ to ___/___/___

Partial: From ___/___/___ to ___/___/___

Special Tests: _____

Referred to: _____

2. Dr. _____

Specialty: _____ Date 1st seen: ___/___/___

Referred by: _____

Treatment type/Frequency/Duration: _____

Still Treating? No Yes Has it Helped No Yes

Disability: Total: From ___/___/___ to ___/___/___

Partial: From ___/___/___ to ___/___/___

Special Tests: _____

Referred to: _____

Please provide the details of other doctors seen on back.

No-Fault Injury History Form

Current Complaints:

1. Area/Location: _____

Sharp Dull Burning Throbbing Radiating

Other: _____

When did symptom begin?: _____

Aggravated by: _____

Relieved by: _____

Radiates to: _____

Severity: Minimal Mild Moderate Severe

Frequency: 10-25% 26-50% 51-75% 76-100%

2. Area/Location: _____

Sharp Dull Burning Throbbing Radiating

Other: _____

When did symptom begin?: _____

Aggravated by: _____

Relieved by: _____

Radiates to: _____

Severity: Minimal Mild Moderate Severe

Frequency: 10-25% 26-50% 51-75% 76-100%

3. Area/Location: _____

Sharp Dull Burning Throbbing Radiating

Other: _____

When did symptom begin?: _____

Aggravated by: _____

Relieved by: _____

Radiates to: _____

Severity: Minimal Mild Moderate Severe

Frequency: 10-25% 26-50% 51-75% 76-100%

4. Area/Location: _____

Sharp Dull Burning Throbbing Radiating

Other: _____

When did symptom begin?: _____

Aggravated by: _____

Relieved by: _____

Radiates to: _____

Severity: Minimal Mild Moderate Severe

Frequency: 10-25% 26-50% 51-75% 76-100%

Self Assess Overall Improvement as of today:

(% Improvement for each area of complaint)

Original Complaints (If accident not recent):

1. Area/Location: _____

Sharp Dull Burning Throbbing Radiating

Other: _____

When did symptom begin?: _____

Aggravated by: _____

Relieved by: _____

Radiates to: _____

Severity: Minimal Mild Moderate Severe

Frequency: 10-25% 26-50% 51-75% 76-100%

2. Area/Location: _____

Sharp Dull Burning Throbbing Radiating

Other: _____

When did symptom begin?: _____

Aggravated by: _____

Relieved by: _____

Radiates to: _____

Severity: Minimal Mild Moderate Severe

Frequency: 10-25% 26-50% 51-75% 76-100%

3. Area/Location: _____

Sharp Dull Burning Throbbing Radiating

Other: _____

When did symptom begin?: _____

Aggravated by: _____

Relieved by: _____

Radiates to: _____

Severity: Minimal Mild Moderate Severe

Frequency: 10-25% 26-50% 51-75% 76-100%

4. Area/Location: _____

Sharp Dull Burning Throbbing Radiating

Other: _____

When did symptom begin?: _____

Aggravated by: _____

Relieved by: _____

Radiates to: _____

Severity: Minimal Mild Moderate Severe

Frequency: 10-25% 26-50% 51-75% 76-100%

Comments and/or Describe other areas of complaint:

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Name: _____ Date: _____

D/I: _____ Chief Complaints: _____

The purpose of this form is to elaborate on how your accident has and continues to affect your life style.

As a result of this accident, did you have any changes in your work status? []Yes []No

If yes, did you:

- Miss work? (Indicate dates)
- Experience limitations in your work hours? (Describe)
- Experience limitation in your work capacities? (Describe)

As a result of this accident, have you had any changes in your lifestyle? []Yes []No

If Yes, has your pain worsened by or have you had difficulty with:

- | | | |
|---|--|---|
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Reaching out with arms | <input type="checkbox"/> Knee Movement |
| <input type="checkbox"/> Stooping | <input type="checkbox"/> Reaching arms over-head | <input type="checkbox"/> Going up stairs |
| <input type="checkbox"/> Twisting | <input type="checkbox"/> Coughing | <input type="checkbox"/> Going down stairs |
| <input type="checkbox"/> Kneeling | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Prolonged Sitting |
| <input type="checkbox"/> Squatting | <input type="checkbox"/> Stretching | <input type="checkbox"/> Prolonged Standing |
| <input type="checkbox"/> Crawling | <input type="checkbox"/> Shoulder Movement | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Climbing | <input type="checkbox"/> Head Movement | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Bending Forward | <input type="checkbox"/> Looking up | <input type="checkbox"/> Laying on back |
| <input type="checkbox"/> Bending Backward | <input type="checkbox"/> Looking Down | <input type="checkbox"/> Laying on side |
| <input type="checkbox"/> Bending sideward | <input type="checkbox"/> Turning Head | <input type="checkbox"/> Sudden Movements |

Explain/Elaborate above restrictions: _____

As a result of this accident, have any of your recreational activities been affected? []Yes []No

- | | | |
|--|---|--|
| <input type="checkbox"/> Long walks | <input type="checkbox"/> Golfing | <input type="checkbox"/> Hiking |
| <input type="checkbox"/> Bicycle riding | <input type="checkbox"/> Softball | <input type="checkbox"/> Camping |
| <input type="checkbox"/> Working out | <input type="checkbox"/> Other sports _____ | <input type="checkbox"/> Traveling |
| <input type="checkbox"/> Lifting Weights | _____ | <input type="checkbox"/> Sexual activity |

Other/Comments: _____

AS A RESULT OF THIS ACCIDENT CIRCLE ALL ABOVE ITEMS THAT CONTINUES TO BE A PROBLEM.

AS A RESULT OF THIS ACCIDENT, DO YOU HAVE ANY CONCERNS ABOUT DRIVING? []YES []NO

Describe: _____

{PLEASE USE BACK OF FORM FOR ADDITIONAL COMMENTS, IF NECESSARY}