MORNINGSTAR CHIROPRACTIC
SPINAL CORRECTION CENTER

PERSONAL INJURY PATIENT HISTORY

Name ____ **Date** _____________

Insurance Company:________________ **Claim Number:** ________________________

Adjuster's Name:______________________ **Insurance Phone #:**___________________

1. Date of Accident: _______________ Time:______________ AM/PM
2. Driver of Car: ____
3. Where were you seated? ____________________________________
4. Who owns the car? ____
5. Year & Model of your car. __________________________________

   Year & Model of the **other car**: _______________________________

6. What was the approximate damage done to your car? $________________
7. Visibility at time of accident: Poor Fair Good Other: _______
8. Road Conditions at time of accident: Icy Rainy Wet Clear Dark

   Other (describe): ____

9. In your own words, please describe the accident: ______________________

   ____

   ____

10. Type of Accident: Head-on Collision Broad-side Collision Front Impact

    Rear Impact Non- collision

11. At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car: ______________________________
12. Did you see the accident coming? Yes No
13. Did you brace for impact? Yes No
14. Were seatbelts worn? Yes No
15. Were shoulder harnesses worn? Yes No

16. Does your car have headrests? Yes No

17. If yes, what was the position of the headrest compared to your head before the accident?

Top of headrest even with **bottom** of head

Top of headrest even with **top** of head

Top of headrest even with **middle** of neck

18. Was your car braking? Yes No

19. Was your car moving at the time of the accident? Yes No

20. If yes, how fast would you estimate you were going? _______________ mph

21. How fast would you estimate the other car was going? _______________ mph

22. Head/ Body position at the time of impact:

Head turned left / right	Body straight in sitting position
Head looking back	Body rotated right / left
Head straight forward	Other:____________________________

23. As a result of the accident you were: Rendered unconscious In shock

Dazed, Other: ____________________

24. How was the shoulder harness adjusted? Loose Snug

25. Were you wearing a hat or glasses? Yes No

26. Could you move all parts of your body? Yes No

27. If no, what parts couldn't you move and why?

____

28. Were you able to get out of the car and walk unaided? Yes No

29. If no, why not? ____

30. Did you have any bleeding? Yes No If yes, where? _____________________

31. Did you have any bruises? Yes No If yes, where? _____________________

32. Please describe how you felt:

Immediately after the accident: ____

Later that day: ____

The **next** day: ____

33. Check symptoms apparent since the accident:

Headache	Neck pain / stiffness	Mid back pain
Eyes light sensitive	Pain behind eyes	Dizziness
Fainting	Sleeping problems	Numbness in fingers
Numbness in toes	Loss of smell	Loss of taste
Loss of memory	Fatigue	Breath shortness
Irritability	Depression	Ear ringing / buzzing

Loss of balance	Tension	Cold hands
Cold feet	Diarrhea	Constipation
Chest pain	Nervousness	Cold sweats
Anxious	Facial pain	Clicking or popping jaw
Low back pain	Other: ___________________________________	

34. Occupation: ____

35. Employer: ____

36. Have you missed **any** time from work: Yes No

37. If yes, full time off work: ____________________ to ___________________

38. If yes, part time off work: ____________________ to ___________________

39. Did you seek **any** medical help immediately after the accident? Yes No

40. If yes, how did you get there? Ambulance Police

    Someone else drove me Drove own car Other: ________________

41. Doctor #1 / Hospital Name: ____

42. First Visit Date: ____

43. Were you examined? Yes No **Admitted?** Yes No

44. Were X-rays taken? Yes No **Other tests:** _______________

45. Did you receive treatment? Yes No Medications Braces Collars

46. If yes, what kind of treatment did you receive? _________________________

47. What benefits did you receive from the treatment? ______________________

48. Date of last treatment: ____

49. Doctor #2 / Office Name: ____

50. First Visit Date: ____

51. Were you examined? Yes No

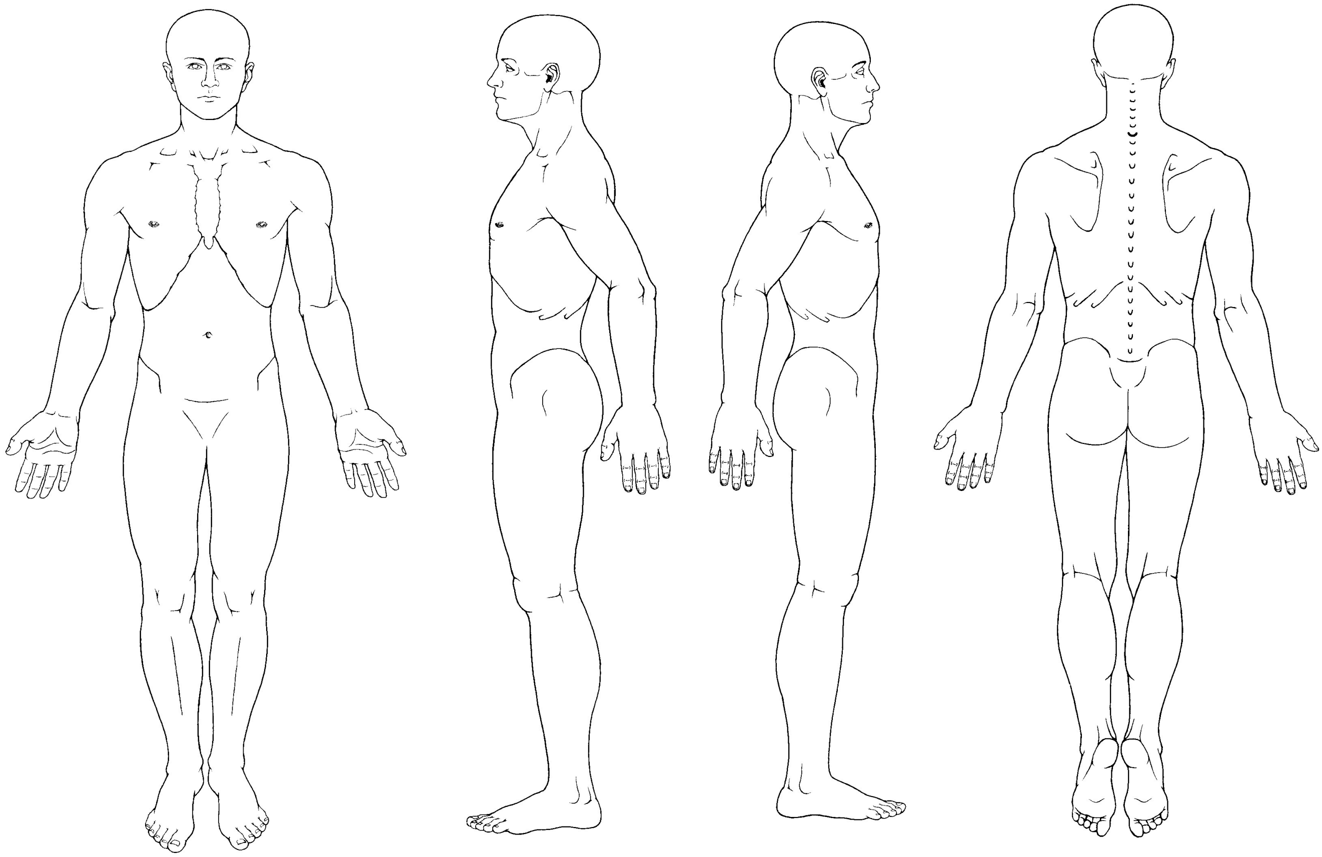
52. Were X-rays taken? Yes No

53. Did you receive treatment? Yes No

54. If yes, what kind of treatment did you receive? _________________________

55. What benefits did you receive from the treatment? ______________________

56. Date of last treatment: ____



Please mark off *ALL the current areas* of your complaint(s) on the diagrams above. Please use the following symbols on the pain diagram to accurately describe your condition.

PPP	**Where you experience Pain**
NNN	**Where you experience Numbness**
TTT	**Where you experience Tingling**
BBB	**Where you experience Burning**
SSS	**Where you experience Spasm**

Please rate your symptoms below relating to where you condition is today.

NO Pain/Numb/etc.												Pain/Numb/Tingle
All Activities OK	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Activity Difficulty
Best Ever Felt												**Worst Ever Felt**

***PATIENT SIGNITURE*______________________________________ *DATE*_____________**