**Dr. Randall D. Trester**
West 1st Chiropractic Wellness Centre

3 - 1864 West 1st Ave
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www.drrandalltrester.com

a division of
Dr. Randall D. Trester Chiropractic Corporation

# Personal Injury History Form

## GENERAL

Name | Date

Driver's Auto Ins. Co. | Policy #

Claim Adjuster's Name | Phone #

Attorney's Name | Attorney's Phone #

Attorney's Address

## NATURE OF ACCIDENT

Date of Accident | Time of Day

Were you the ☐ Driver ☐ Passenger Front ☐ Back Seat (☐ Right Side ☐ Left Side) ☐ Pedestrian

☐ Other

Number of people in your car?

Did your car strike the other car? ☐ Yes ☐ No Did the other car strike yours? ☐ Yes ☐ No

How many impacts were there?

Were you struck from? ☐ Front ☐ Rear (☐ Left Side ☐ Right Side) ☐ Other

Which direction were you headed? ☐ N ☐ S ☐ E ☐ W Other(s) headed? ☐ N ☐ S ☐ E ☐ W

What was your approximate speed? Other(s) speed?

What type of car were you in? Other car?

Was your foot on the brake? ☐ Yes ☐ No

Were the roads? ☐ Dry ☐ Wet ☐ Icy

Were the police notified? ☐ Yes ☐ No

Was your car towed away? ☐ Yes ☐ No Other(s)? ☐ Yes ☐ No

Were you wearing a seat belt? ☐ Yes ☐ No Shoulder strap? ☐ Yes ☐ No

Did an air bag stop your body's motion? ☐ Yes ☐ No

Does your car have a headrest? ☐ Yes ☐ No

Height or Position of headrest? ☐ Shoulder ☐ Neck ☐ Head ☐ Above

Were you aware of the impending impact? ☐ Yes ☐ No

Which direction were you looking at the time of impact? ☐ Left ☐ Right ☐ Downward ☐ Upward ☐ Straight Ahead

☐ Other

Did your body hit anything in the vehicle? ☐ Yes ☐ No If "Yes" please explain

Did you lose consciousness? ☐ Yes ☐ No If "Yes" how long?

In your own words, please describe the accident

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# Personal Injury History Form cont'd

## PREVIOUS TREATMENT

Were you taken to the hospital? ☐ Yes ☐ No Which one?

What was done?

Were you treated in any way?

Have you seen any other doctors since the accident? ☐ Yes ☐ No Who?

What was done?

Any other doctors?

What type of treatment was done?

Have you taken any other medication (over the counter)? ☐ Yes ☐ No If "yes" please explain:

## PREVIOUS HISTORY

Did you have any physical complaints BEFORE THE ACCIDENT? ☐ Yes ☐ No

If "yes" please describe in detail:

Do you have any previous illnesses which relate to this case? ☐ Yes ☐ No

If "yes" please describe:

Have you had any previous auto accidents? ☐ Yes ☐ No If "yes" please describe in detail:

Were you treated for any of these injuries? ☐ Yes ☐ No

How long was your care?

Were you released from care? ☐ Yes ☐ No If "no" please explain:

Have you had any previous injuries (work related, slips and falls, etc)? ☐ Yes ☐ No

If "yes" please explain in detail:

Were you treated for any of these injuries? ☐ Yes ☐ No

Were you released from care? ☐ Yes ☐ No If "no" please explain:

Who is your employer?

What is your type of employment?

Have you missed any time from work since the accident? ☐ Yes ☐ No

If working are you working at full capacity? ☐ Yes ☐ No If "no" please explain:

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# Personal Injury History Form cont'd

## CURRENT CONDITIONS

Describe how you felt:

DURING the accident

IMMEDIATELY AFTER the accident

LATER THAT DAY

THE NEXT DAY

INSTRUCTIONS: Please check symptoms you have experienced since the accident.

- ☐ Headaches
- ☐ Skull or Head Pain
- ☐ Neck Pain
- ☐ Neck Stiffness
- ☐ Head Feel Too Heavy
- ☐ Shoulder Pain
- ☐ Shoulder Stiffness
- ☐ Arm Pain
- ☐ Arm Numbness (☐Pins & Needles in Arms)
- ☐ Numbness in Hands/Fingers
- ☐ Cold Hands
- ☐ Upper Back Pain
- ☐ Upper Back Stiffness
- ☐ Mid Back Pain
- ☐ Mid Back Stiffness
- ☐ Chest Pains
- ☐ Rib Pain
- ☐ Painful Breathing
- ☐ Low Back Pain
- ☐ Low Back Stiffness
- ☐ Hip Pain
- ☐ Buttock Pain
- ☐ Leg Pain
- ☐ Leg Numbness (☐Pins & Needles in Legs)
- ☐ Numbness in Toes & Feet
- ☐ Cold Feet
- ☐ Depression
- ☐ Anxiety
- ☐ Tension
- ☐ Irritability
- ☐ Nervousness
- ☐ Mental Dullness
- ☐ Loss of Memory
- ☐ Difficulty Sleeping
- ☐ Fatigue
- ☐ Tremors
- ☐ Face Flush
- ☐ Loss of Colour
- ☐ Dizziness
- ☐ Fainting
- ☐ Sinus Trouble
- ☐ Loss of Smell
- ☐ Eye Strain
- ☐ Difficulty Focusing
- ☐ Pain Behind Eyes
- ☐ Eyes Sensitive to Light
- ☐ Double Vision
- ☐ Buzz/Ringing in Ears
- ☐ Loss of Balance
- ☐ Palpitation
- ☐ Shortness of Breath
- ☐ Digestive Problems
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Excess Perspiring
- ☐ Loss of Perspiring
- ☐ Loss of Taste
- ☐ Cold Sweats
- ☐ Fever
- ☐ Swelling
- ☐ Difficulty in:
- ☐ Prolonged/Excessive
  - ☐ Riding in Car
  - ☐ Bending
  - ☐ Standing
  - ☐ Sitting
  - ☐ Walking
  - ☐ Lifting
  - ☐ Twisting/Turning
- ☐ Difficulty rising to walk
- ☐ Pain doing Job

Any other symptoms not listed

Since this injury occurred, are your symptoms: ☐ Improving ☐ Getting worse ☐ Same

Do you notice any activity restrictions as a result of this injury? ☐ Yes ☐ No

If "yes" then please explain in detail

Other pertinent information

I have answered the previous questions to the best of my ability by signing below.

Signature Date