

# WellnessOne Personal Injury History

## General information:

Patient name: \_\_\_\_\_  
Today's date: \_\_\_\_\_  
Date of injury: \_\_\_\_\_  
Marital status:  M  S  W  D  
Habits:  
Smoke:  None Pk/day \_\_\_\_\_ Years \_\_\_\_\_  
Alcohol:  Never  Social  Light  Mod.  
 Heavy  
Employment:  
At time of crash: \_\_\_\_\_  
 Unemployed  
Currently: \_\_\_\_\_  
 Unemployed  
Due to crash?  Yes  No  
Type of work:  Office/clerical  Light labor  
 Moderate labor  Heavy labor

## Past medical history:

Surgeries (dates and residuals): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Fractures (dates and residuals): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Serious illness (dates and residuals): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Workers' comp. injuries (date, treatment, awards, residuals): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Personal Injuries (date, treatment, awards, residuals) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Sports or other injuries to head, neck, or back: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Past medical history (cont'd)

Any prior HISTORY of current complaints:  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
Prior treatment by a Chiropractor for these:  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
Current Medical history:  
Current health problems:  None  
\_\_\_\_\_  
Current medications taken:  None  
\_\_\_\_\_

## Injury history:

Was the crash on-the-job?  Yes  No  
You were:  Driver  Front seat passenger  
 Rear seat passenger  Motorcycle operator  
 Motorcycle passenger  Other \_\_\_\_\_  
Vehicle driven by: \_\_\_\_\_  
Your vehicle (year, make, model): \_\_\_\_\_  
Your estimated speed at moment of crash: \_\_\_\_\_  
 Stopped  Slowing  Accelerating  
Other vehicle (year, make, model): \_\_\_\_\_  
Time of day:  Daylight  Dawn  Dusk  
 Dark  
Road conditions:  Dry  Damp  Wet  
 Snow  Ice  Other \_\_\_\_\_  
Head restraints:  None  Integral type  
 Adjustable type:  Up  Down  
 Don't know  
If adjustable, was the position altered by the crash?  Yes  No  
Was the seat back adjustment altered by the crash?  Yes  No  
Was the seat broken?  Yes  No  
Lap belt:  Wearing  Not wearing  
 Don't know  
Shoulder belt:  None  Wearing  
 Not wearing  Don't know  
Did air bag deploy?  Yes  No  
If yes, were you struck?  Yes  No  
Body position:  Good  Forward lean  
Other \_\_\_\_\_  
Head position:  Forward  Left \_\_\_\_°  
 Right \_\_\_\_°  Up \_\_\_\_°  Down \_\_\_\_°



Injury history: (cont'd)

Hands:  One on wheel  Two on wheel  
 N/A

Brakes applied?  Yes  No

Crash description: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Crash diagram:



Aware of impending crash?  Yes  No

### During the crash:

Did you strike any parts of the vehicle?  Y  N

If yes, describe \_\_\_\_\_

Did vehicle strike any objects after crash?

If yes, describe \_\_\_\_\_

Wearing hat or glasses?  Yes  No

If yes, still on after crash?  Yes  No

Did you lose consciousness?  Yes  No

If yes, for how long? \_\_\_\_\_

Estimated property damage to your vehicle:

\$ \_\_\_\_\_

Estimated damage to other vehicle(s):  None

Minimal  Moderate  Major

Were the police on-scene?  Yes  No

If yes, was a report made?  Yes  No

### After the crash:

Symptoms:  Headache  Dizziness  Nausea

Confusion/disorientation  Neck pain

Paresthesia(s)

If yes, where? \_\_\_\_\_

Extremity pain. If yes, where? \_\_\_\_\_

Back pain

When did symptoms first appear?  Immediately  
(describe which symptom) \_\_\_\_\_ hr afterward

Where did you go after crash?  Home

Work  Hospital:

Mode of transportation \_\_\_\_\_

Pvt. doctor: \_\_\_\_\_

### Emergency department:

Radiographs:  Yes  No

Body parts imaged \_\_\_\_\_

Results \_\_\_\_\_

Lab work  Yes  No \_\_\_\_\_

Cervical collar  Ice

Medications: \_\_\_\_\_

Other: \_\_\_\_\_

Follow-up instructions:  None \_\_\_\_\_

### Treatment history:

1. Dr.: \_\_\_\_\_

Specialty: \_\_\_\_\_ Date first seen: \_\_\_\_\_

Referred by: \_\_\_\_\_ Treatment type: \_\_\_\_\_

Treatment frequency: \_\_\_\_\_ Duration: \_\_\_\_\_

Currently treating?  Yes  No

Any disability?  Yes  No

If yes, describe: \_\_\_\_\_

Special tests: \_\_\_\_\_

Referred to: \_\_\_\_\_

Treatment help?  Yes  No

Notes: \_\_\_\_\_

2. Dr.: \_\_\_\_\_

Specialty: \_\_\_\_\_ Date first seen: \_\_\_\_\_

Referred by: \_\_\_\_\_ Treatment type: \_\_\_\_\_

Treatment frequency: \_\_\_\_\_ Duration: \_\_\_\_\_

Currently treating?  Yes  No

Any disability?  Yes  No

If yes, describe: \_\_\_\_\_

Special tests: \_\_\_\_\_

Referred to: \_\_\_\_\_

Treatment help?  Yes  No

Notes: \_\_\_\_\_



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Treatment history: (cont'd)

3. Dr.: \_\_\_\_\_  
Specialty: \_\_\_\_\_ Date first seen: \_\_\_\_\_  
Referred by: \_\_\_\_\_ Treatment type: \_\_\_\_\_  
Treatment frequency: \_\_\_\_\_ Duration: \_\_\_\_\_  
Currently treating?  Yes  No  
Any disability?  Yes  No  
If yes, describe: \_\_\_\_\_  
Special tests: \_\_\_\_\_  
Referred to: \_\_\_\_\_  
Treatment help?  Yes  No  
Notes: \_\_\_\_\_  
\_\_\_\_\_

4. Dr.: \_\_\_\_\_  
Specialty: \_\_\_\_\_ Date first seen: \_\_\_\_\_  
Referred by: \_\_\_\_\_ Treatment type: \_\_\_\_\_  
Treatment frequency: \_\_\_\_\_ Duration: \_\_\_\_\_  
Currently treating?  Yes  No  
Any disability?  Yes  No  
If yes, describe: \_\_\_\_\_  
Special tests: \_\_\_\_\_  
Referred to: \_\_\_\_\_  
Treatment help?  Yes  No  
Notes: \_\_\_\_\_  
\_\_\_\_\_

5. Dr.: \_\_\_\_\_  
Specialty: \_\_\_\_\_ Date first seen: \_\_\_\_\_  
Referred by: \_\_\_\_\_ Treatment type: \_\_\_\_\_  
Treatment frequency: \_\_\_\_\_ Duration: \_\_\_\_\_  
Currently treating?  Yes  No  
Any disability?  Yes  No  
If yes, describe: \_\_\_\_\_  
Special tests: \_\_\_\_\_  
Referred to: \_\_\_\_\_  
Treatment help?  Yes  No  
Notes: \_\_\_\_\_  
\_\_\_\_\_

6. Dr.: \_\_\_\_\_  
Specialty: \_\_\_\_\_ Date first seen: \_\_\_\_\_  
Referred by: \_\_\_\_\_ Treatment type: \_\_\_\_\_  
Treatment frequency: \_\_\_\_\_ Duration: \_\_\_\_\_  
Currently treating?  Yes  No  
Any disability?  Yes  No  
If yes, describe: \_\_\_\_\_  
Special tests: \_\_\_\_\_  
Referred to: \_\_\_\_\_  
Treatment help?  Yes  No  
Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Original chief complaints  
(if injury was not recent):**

1. Body part/system: \_\_\_\_\_  
Onset: \_\_\_\_\_  
Provocative: \_\_\_\_\_  
Palliative: \_\_\_\_\_  
Quality: \_\_\_\_\_  
Radiation: \_\_\_\_\_  
Severity (1-10): \_\_\_\_\_  
Temporal: \_\_\_\_\_

2. Body part/system: \_\_\_\_\_  
Onset: \_\_\_\_\_  
Provocative: \_\_\_\_\_  
Palliative: \_\_\_\_\_  
Quality: \_\_\_\_\_  
Radiation: \_\_\_\_\_  
Severity (1-10): \_\_\_\_\_  
Temporal: \_\_\_\_\_

3. Body part/system: \_\_\_\_\_  
Onset: \_\_\_\_\_  
Provocative: \_\_\_\_\_  
Palliative: \_\_\_\_\_  
Quality: \_\_\_\_\_  
Radiation: \_\_\_\_\_  
Severity (1-10): \_\_\_\_\_  
Temporal: \_\_\_\_\_

4. Body part/system: \_\_\_\_\_  
Onset: \_\_\_\_\_  
Provocative: \_\_\_\_\_  
Palliative: \_\_\_\_\_  
Quality: \_\_\_\_\_  
Radiation: \_\_\_\_\_  
Severity (1-10): \_\_\_\_\_  
Temporal: \_\_\_\_\_

5. Body part/system: \_\_\_\_\_  
Onset: \_\_\_\_\_  
Provocative: \_\_\_\_\_  
Palliative: \_\_\_\_\_  
Quality: \_\_\_\_\_  
Radiation: \_\_\_\_\_  
Severity (1-10): \_\_\_\_\_  
Temporal: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Current chief complaints:**

1. Body part/system: \_\_\_\_\_  
Onset: \_\_\_\_\_  
Provocative: \_\_\_\_\_  
Palliative: \_\_\_\_\_  
Quality: \_\_\_\_\_  
Radiation: \_\_\_\_\_  
Severity (1-10): \_\_\_\_\_  
Temporal: \_\_\_\_\_

2. Body part/system: \_\_\_\_\_  
Onset: \_\_\_\_\_  
Provocative: \_\_\_\_\_  
Palliative: \_\_\_\_\_  
Quality: \_\_\_\_\_  
Radiation: \_\_\_\_\_  
Severity (1-10): \_\_\_\_\_  
Temporal: \_\_\_\_\_

3. Body part/system: \_\_\_\_\_  
Onset: \_\_\_\_\_  
Provocative: \_\_\_\_\_  
Palliative: \_\_\_\_\_  
Quality: \_\_\_\_\_  
Radiation: \_\_\_\_\_  
Severity (1-10): \_\_\_\_\_  
Temporal: \_\_\_\_\_

4. Body part/system: \_\_\_\_\_  
Onset: \_\_\_\_\_  
Provocative: \_\_\_\_\_  
Palliative: \_\_\_\_\_  
Quality: \_\_\_\_\_  
Radiation: \_\_\_\_\_  
Severity (1-10): \_\_\_\_\_  
Temporal: \_\_\_\_\_

5. Body part/system: \_\_\_\_\_  
Onset: \_\_\_\_\_  
Provocative: \_\_\_\_\_  
Palliative: \_\_\_\_\_  
Quality: \_\_\_\_\_  
Radiation: \_\_\_\_\_  
Severity (1-10): \_\_\_\_\_  
Temporal: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Self assessment as of today: % improved (list for separate areas)**

\_\_\_\_\_  
\_\_\_\_\_

**Request records:**

- 1. Request radiographs from: \_\_\_\_\_
- 2. Request records from: \_\_\_\_\_
- 3. Request copy of police report.

**Referral:**

- For: \_\_\_\_\_
- To: \_\_\_\_\_

**Tests to order:**

- Radiographs: \_\_\_\_\_
- Tomograms: \_\_\_\_\_
- CT: \_\_\_\_\_  
Area(s): \_\_\_\_\_
- MRI: \_\_\_\_\_  
Area(s): \_\_\_\_\_
- MRA: \_\_\_\_\_  
Area(s): \_\_\_\_\_
- Scintigraphy/SPECT: \_\_\_\_\_  
Area(s): \_\_\_\_\_
- Videofluoroscopy: \_\_\_\_\_  
Area(s): \_\_\_\_\_
- EMG/NCV: \_\_\_\_\_  
Root level/nerve(s): \_\_\_\_\_
- SEP: \_\_\_\_\_  
Root level/nerve(s): \_\_\_\_\_
- Other electrodiagnostic test(s): \_\_\_\_\_
- Ultrasound: \_\_\_\_\_  
Area(s): \_\_\_\_\_

**Action taken on this visit:**

- Exam/TX: \_\_\_\_\_
- Place on disability: \_\_\_\_\_
- Work restriction: \_\_\_\_\_
- Referral: \_\_\_\_\_
- Brace/collar: \_\_\_\_\_
- Home traction device: \_\_\_\_\_
- PT: \_\_\_\_\_
- Supplements: \_\_\_\_\_
- Other: \_\_\_\_\_

