WILLIAMSTON WELLNESS, PLLC
PERSONAL INJURY HISTORY FORM

Today's Date _____

PATIENT NFORMATION:

Name_____Age_____Date of Birth_____/_____/_____Gender: M F T

Home Address_____City_____State_____Zip_____

Home/Cell Phone_____Alt. Phone_____

Email_____

ACCIDENT DETAILS:

Date of Accident ____/_____/_____ Time of Accident _____ ☐ AM ☐ PM Location_____

What type of accident? ☐ Workers Comp ☐ Auto- while on job ☐ Slip & Fall ☐ Other_____

Did you lose consciousness? ☐ Yes ☐ No If yes, how long_____

Were the police notified? ☐ Yes ☐ No Is there a report of the accident? ☐ Yes ☐ No

Did you go to the hospital? ☐ Yes ☐ No By ambulance? ☐ Yes ☐ No Were you admitted? ☐ Yes ☐ No

Brief description of accident: _____

_____

_____

Please list any health care practitioners you have seen for this accident and their diagnosis or treatment.

_____

_____

Have you retained an attorney? ☐ Yes ☐ No

Name: _____ Phone: _____

At the time of this injury did you have a job? ☐ Yes ☐ No

Employer/Address _____Occupation _____

Did you miss any work because of your injuries? ☐ Yes ☐ No From:_____/_____/_____ To:_____/_____/_____

AUTO ACCIDENT:

You were the ☐ DRIVER ☐ FRONT PASSENGER ☐ BACK PASSENGER or ☐ PEDESTRIAN

Were police at the accident scene? ☐ Yes ☐ No Is there an accident report? ☐ Yes ☐ No

Were you wearing seatbelt ☐ YES ☐ NO

Has this accident been reported to the auto insurance company? ☐ YES ☐ NO

Was anyone ticketed?_____

Responsible Driver's Name _____Policy Holder's Name_____

Policy Holder's Auto Insurance Co _____

PIP Adjuster: _____ Phone #: _____ PIP Claim #: _____

Policy Holder's Phone Number_____

WORKERS COMPENSATION ACCIDENT:

W/C Carrier_____Claim# _____

Who is/was your employer at the time of injury? _____

Employer Address_____

Employer Phone Number_____Supervisor's Name_____

Was there an accident report filed? ☐ Yes ☐ No

SLIP AND FALL ACCIDENT:

Responsible Party's Name:_____Policy#_____

Insurance Co. Name_____Claim#_____

Adjuster Name_____ Phone#:_____

Were you carrying anything in your hands at the time of your fall? ☐ Yes ☐ No ,if yes what? _____

How did you land? _____

What caused the obstacle or condition?_____

Did anything fall on you? ☐ Yes ☐ No ,if yes what? _____

Did you hit your face or head? ☐ Yes ☐ No Did your feet go out from underneath you? ☐ Yes ☐ No

Do you have any (cuts / bruises) ☐ Yes ☐ No If yes, where: _____

INJURY DETAILS:

List the extent of injuries as you know them_____

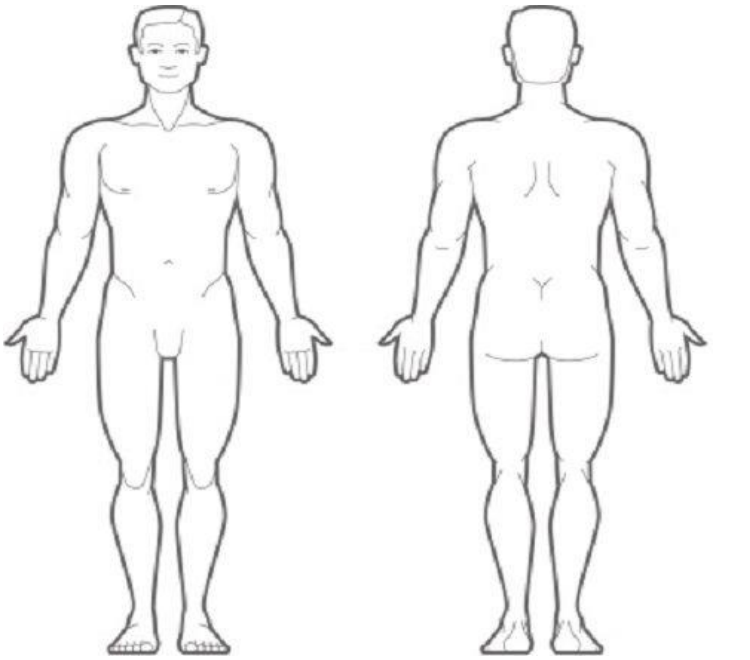
_____

_____

Check any symptoms you have experienced since the accident:

☐ HEADACHE ☐ DIZZINESS
☐ DEPRESSION ☐ FATIGUE
☐ LOSS OF TASTE ☐ STOMACH UPSET
☐ LIGHT BOTHERS EYES ☐ BUZZING IN EARS
☐ DIARRHEA ☐ NECK PAIN
☐ HEAD SEEMS HEAVY ☐ PINS & NEEDLES IN ARMS
☐ COLD FEET ☐ STIFF KNECK
☐ LOSS OF MEMORY ☐ EAR RINGING
☐ SLEEPING PROBLEMS ☐ COLD HANDS
☐ FAINTING ☐ LOSS OF BALANCE
☐ BACK PAIN ☐ PINS & NEEDLES IN LEGS
☐ FACE FLUSHED ☐ TENSION
☐ CONSTIPATION ☐ NERVOUSNESS
☐ NUMB FINGER ☐ LOSS OF SMELL
☐ FEVER ☐ IRRITABILITY
☐ NUMBNESS IN TOES ☐ SHORTNESS OF BREATH
☐ COLD SWEATS ☐ CHEST PAIN
☐ OTHER_____

Please circle any areas of pain, injury, tension, or restriction of movement.



Overall, at this time, is your condition: ☐ Becoming worse ☐ Remaining the same ☐Improving

Patient Signature_____**Date:**_____