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## Personal Injury History Form

DATE:

NAME:

DATE OF BIRTH:

DATE OF INJURY/ACCIDENT:

WHAT KIND OF ACCIDENT WERE YOU INVOLVED IN:

CAR ACCIDENT:            DRIVER            PASSENGER            FRONT SEAT            BACK SEAT

SLIP & FALL (INCLUDE LOCATION): \_\_\_\_\_

OTHER: \_\_\_\_\_

EXPLAIN THE ACCIDENT (WHAT HAPPENED?) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

WHERE WAS THE SITE OF IMPACT? WHICH PART OF YOUR BODY WAS INJURED? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

POLICE REPORT FROM THE SCENE:            YES            NO

DID YOU NEED AMBULANCE OR HOSPITAL?            YES            NO

SYMPTOMS IMMEDIATELY AFTER THE ACCIDENT: \_\_\_\_\_

\_\_\_\_\_

CURRENT COMPLAINTS: \_\_\_\_\_

\_\_\_\_\_

PAST INJURIES OF ANY KIND & DATE: \_\_\_\_\_

\_\_\_\_\_