California Cranial Institute
Thomas E. Bloink, DC
431 Monterey Avenue, Suite #1, Los Gatos, CA 95030 Phone: 408-395-8006 Fax: 408-395-7317

PERSONAL INJURY HISTORY FORM

Name ______________________________ Phone ( ) ______________

Address ______________________________ City ____________ ST ____ Zip ________

Age ________ Birthdate ______________ Sex ____ SS # ______________________

Your Auto Insurance Information:

Insurance Company ______________________________ Policy # ______________

Claim # ______________________________ Name on Policy ______________

Agent's Name ______________________________ Agent's Phone ( ) ______________

Ins. Address ______________________________ City ____________ ST ____ Zip ________

Attorney Information:

Name ______________________________ Phone ( ) ______________

Address ______________________________ City ____________ ST ____ Zip ________

Were there any witnesses? ( ) Yes ( ) No Name(s) ______________________________

Nature of Accident:

Date of accident ______________ Approximate time of day ____________

Were you the ( ) Driver ( ) Front Seat Passenger ( ) Back Seat Passenger

Number of people in your vehicle? Were you wearing seat belts? ______________

Which direction was your vehicle heading? ( ) N ( ) E ( ) S ( ) W

Name of street ______________________________

Which direction was the other vehicle heading? ( ) N ( ) E ( ) S ( ) W

Name of street ______________________________

Were you struck from ( ) Behind ( ) Front ( ) Left side ( ) Right Side

Approximate speed of your vehicle ________ mph Other vehicle _______ mph

Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? ______________

Were police notified? ( ) Yes ( ) No

In your own words, please describe accident: ______________________________

____

____

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

If yes, please describe ______________________________

____

____

Please describe how you feel:

During the accident ______________________________

Immediately after the accident ______________________________

Later that day ______________________________

The next day ______________________________

What are your PRESENT complaints and symptoms? ____

____

____

Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No

If yes, please describe ____

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

If yes, please describe ____

Have you ever been involved in an accident before? ( ) Yes ( ) No

If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received ______________

____

____

Where were you taken after the accident? ____

Have you been treated by another doctor since the accident? ( ) Yes ( ) No

If yes, please list doctor's name and address ____

____

What type of treatment did you receive? ____

Since this injury occurred, are your symptoms: ( ) improving ( ) getting worse ( ) same

Check symptoms you have noticed since accident:

( ) Headache	( ) Irritability	( ) Numbness in Toes	( ) Face Flushed	( ) Feet Cold
( ) Neck Pain	( ) Chest Pain	( ) Shortness of Breath	( ) Buzzing in Ears	( ) Hands Cold
( ) Neck Stiff	( ) Dizziness	( ) Fatigue	( ) Loss of Balance	( ) Stomach Upset
( ) Sleeping Prob.	( ) Head Seems too Heavy	( ) Depression	( ) Fainting	( ) Constipation
( ) Back Pain	( ) Pins & Needles - Arms	( ) Lights Bother Eyes	( ) Loss of Smell	( ) Cold Sweats
( ) Nervousness	( ) Pins & Needles - Legs	( ) Loss of Memory	( ) Loss of Taste	( ) Fever
( ) Tension	( ) Pins & Needles – Fingers	( ) Ears Ring	( ) Diarrhea	

( ) Other ____

Have you lost time from work as a result of this accident? ( ) Yes ( ) No

If yes, please complete the following:

Last day worked: ____

Type of employment: ____

Present salary: ____

Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state __________

the type of compensation you are receiving: ____

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

If yes, please describe in detail: ____

____

____

Other pertinent information ____

____

____

____________________________________ ____________________

Patient's Signature Date