

Patient Name: _____ date: _____

Personal Injury Consultation Form

Prior Motor Vehicle Collisions: _____

What Symptoms, Were You Experiencing Prior to the Most Recent Motor Vehicle Collision?

Symptom:	Site:	Intensity: (0-10)	Frequency of Awake Time: (0-100%)
Headaches			
Jaw Pain			
Neck Pain			
Upper Back Pain			
Middle Back Pain			
Low Back Pain			
Other			
Other			
Other			

What Were Your Original Symptoms (1st Few Days) from the Most Recent Motor Vehicle Collision?

Symptom:	Site:	Intensity: (0-10)	Freq. of Awake Time: (0-100%)
Headaches			
Jaw Pain			
Neck Pain			
Upper Back Pain			
Middle Back Pain			
Low Back Pain			
Other			
Other			
Other			

Patient Name: _____ date: _____

What Are Your Current Symptoms from the Most Recent Motor Vehicle Collision?

Symptom:	Site:	Inten- sity: (0- 10)	Freq. of Awake Time: (0-100%)
Headaches			
Jaw Pain			
Neck Pain			
Upper Back Pain			
Middle Back Pain			
Low Back Pain			
Other			
Other			
Other			

What Activities or Positions Make The Pain Worse?

Headaches	
Jaw Pain	
Neck Pain	
Upper Back Pain	
Middle Back Pain	
Low Back Pain	
Other	
Other	
Other	

Patient Name: _____ date: _____

What Activities or Positions Makes The Pain Better?

Headaches	
Jaw Pain	
Neck Pain	
Upper Back Pain	
Middle Back Pain	
Low Back Pain	
Other	
Other	
Other	

Please Describe The Quality of the Pain (circle all that apply):

Headaches	Sharp	Dull	Achy	Burning	Throbbing	Other
Jaw Pain	Sharp	Dull	Achy	Burning	Throbbing	Other
Neck Pain	Sharp	Dull	Achy	Burning	Throbbing	Other
Upper Back Pain	Sharp	Dull	Achy	Burning	Throbbing	Other
Middle Back Pain	Sharp	Dull	Achy	Burning	Throbbing	Other
Low Back Pain	Sharp	Dull	Achy	Burning	Throbbing	Other
Other	Sharp	Dull	Achy	Burning	Throbbing	Other
Other	Sharp	Dull	Achy	Burning	Throbbing	Other
Other	Sharp	Dull	Achy	Burning	Throbbing	Other

Do You Experience any (circle all that apply): Radiating Pain / Numbness / Tingling / Burning / Weakness?

Location: _____

Patient Name: _____ date: _____

Time of Day that the Pain is Worse (circle):

Headaches	Morning	Mid-Day	Evening	Night	Other
Jaw Pain	Morning	Mid-Day	Evening	Night	Other
Neck Pain	Morning	Mid-Day	Evening	Night	Other
Upper Back Pain	Morning	Mid-Day	Evening	Night	Other
Middle Back Pain	Morning	Mid-Day	Evening	Night	Other
Low Back Pain	Morning	Mid-Day	Evening	Night	Other
Other	Morning	Mid-Day	Evening	Night	Other
Other	Morning	Mid-Day	Evening	Night	Other
Other	Morning	Mid-Day	Evening	Night	Other

Are you experiencing any visual disturbance as a result of the collision?

Yes No

Are you experiencing any dizziness as a result of the collision?

Yes No

Are you experiencing any anxiety or depression as a result of the collision?

Yes No