INJURY INFORMATION

Date: _____

Patient Name:_____ **D.O.B.** _____

GENERAL INJURY INFORMATION

How did the accident occur? ❑ Auto ❑ Job ❑ Other

Was a police report filed? ❑ Yes ❑ No

Was a work incident report filed? ❑ Yes ❑ No

Describe your injury and how it occurred:

_____

_____

_____

Describe how you felt during & immediately after the injury:

_____

_____

Later that same day: _____

_____

Next day: _____

_____

Next week:_____

_____

Next month:_____

_____

Describe any bruises, cut, or abrasions as a result of the injury:

_____

_____

Did you go to the emergency room? ❑ Yes ❑ No

Were you hospitalized? ❑ Yes ❑ No

Are your symptoms...

❑ getting better ❑ getting worse ❑ no change

What makes them better?_____

_____

Worse?_____

_____

Did you return to work on the day of the injury? ❑ Yes ❑ No

What are your work responsibilities?

_____

_____

Which work activities are affected by this injury?

_____

_____

Have your work responsibilities changed as a result of this injury?

❑ Yes ❑ No

Explain _____

_____

_____

What other daily activities are affected by this injury?

_____

_____

List the health care providers who have treated you for the injury, the type of treatment provided and the diagnosis.

_____

_____

_____

_____

Have you ever had this type of injury before? ❑ Yes ❑ No

Explain_____

_____

_____

Did you have any physical complaints before the injury?

❑ Yes ❑ No

Explain_____

_____

Do you have any illnesses or previous injuries that may have been affected by this injury? ❑ Yes ❑ No

Explain _____

_____

_____

MOTOR VEHICLE ACCIDENT INFORMATION

Did the police arrive at the accident? ❑ Yes ❑ No

How as your vehicle hit?

❑ Rear End ❑ Head On ❑ Side Swipe

Or did you vehicle hit another vehicle or object?

❑ Rear End ❑ Head On ❑ Side Swipe

If you were hit from behind, was you vehicle pushed forward upon impact? ❑ Yes ❑ No

If yes, how much?

_____

Did your vehicle hit anything else after the initial impact?

❑ Yes ❑ No

Explain_____

_____

Were you at a stop or moving at the time of impact?

❑ Stopped ❑ Moving

If you were stopped, was your foot on the brake?

❑ Yes ❑ No

If you were moving, were you: ❑ Increasing speed
❑ Decreasing Speed
❑ At a steady speed

Was the other vehicle moving at the time of impact?

❑ Yes, if so ❑ Increasing speed ❑ Decreasing speed
❑ Traveling at steady speed
❑ No

Where were you seated in the vehicle? _____

_____

Which way was your head facing upon impact?

_____

_____

Were you aware of the approaching vehicle or did the impact catch you by surprise?
❑ Aware ❑ Surprise

Did you lose consciousness? ❑ Yes ❑ No

Were you wearing a seat belt?
❑ No ❑ Lap belt ❑ Shoulder harness ❑ Both

Is your vehicle equipped with air bags? ❑ Yes ❑ No
Did they activate? ❑ Yes ❑ No

Is the top of your head rest: ❑ above your head
❑ below your head

Does you head touch the head rest? ❑ Yes ❑ No

If no, how far in front of the head rest is your head?

_____

What were the road conditions? ❑ Wet ❑ Dry ❑ Icy ❑ Oily

What type of vehicle hit you? (make, model, year)

_____

Did any part of your body come into contact with the vehicle? ❑ Yes ❑ No

Explain_____

_____

_____

Did any parts of the vehicle break? ❑ Yes ❑ No

Explain_____

_____

_____

Check all of the following symptoms that you have experienced since the accident:

❑ Loss of Memory ❑ Loss of Balance
❑ Visual disturbances ❑ Hearing Difficulty
❑ Difficulty breathing ❑ Sleep disturbances

Anything else you want to tell me about the accident or how you feel?

_____

_____

_____

_____