

Mark With an X

Today's Date _____ Name _____
Date of Birth ___/___/___ Age _____ Employer at time of the accident? 001 _____
Job Title or Description? _____ Length of time employed there? 002 _____
Date of accident 003 ___/___/___ Time accident happened? _____ AM _____ PM
In your Own Words, Describe in Detail the Accident (Where Were You? What were You Doing? How the accident happened?. What Positions Were You In?)
004 _____

What was the Weather at time of the accident? Unimportant Or If Important
005 Clear 006 Raining Snow 007 Other: _____
Were you unconscious?.....008 Yes 009 No
In a daze?.....010 Yes No
Describe how you felt immediately after accident? 011 _____
Did you go to the hospital right away?.....012 Yes No
Name of hospital? _____
013 Went Later, When? _____ Name of hospital? _____
Were you x-rayed there? 014 Yes 015 No
What treatment did you receive?.....016 Medication ... Type _____
017 Other: _____
Name of Doctor you saw? 018 _____
What Diagnosis were you given? 019 _____
What recommendations did the Doctor make? Go See
020 Own Doctor 021 Neurologist 022 Orthopedist 023 Physical-Therapy
024 Other: _____
Have you seen any other doctor as a result of this accident? 025 No
026 Yes Dr. _____
Are you?..... 027 Unchanged 028 Improved, if so % better _____ 029 Getting Worse
Have you lost any time from work because of this accident?...030 No
If Yes, Dates 031 From _____ To _____
Do you feel you can perform physical work activities now?...032 Yes 033 No
Generally speaking, is your inability to perform these functions due to?
034 Pain 035 Weakness 036 Structural Limitations 037 Nerves
038 Other: _____
Do you feel your present condition is?.....039 Temporary 040 Permanent
Any previous permanent injury condition as a result of prior accidents, injuries or illness?...041 No 042 Yes
If Yes, describe When and What _____
Have you had any surgeries?.....043 No 044 Yes
If YES, list date of surgery type and outcome: _____
Have you received a medical discharge from the Armed Forces? No 045 Yes
When? _____ For? _____
Please list any additional comments: 046 _____

Patient Signature _____ Date _____

Mark With an X

NAME _____ DATE _____

DISCOMFORT = can do it but bothers or irritates you then or later on.

PAINFUL = you may still be able to do it but causes pain every time you do.

UNABLE = the pain is so bad that you can not do it at all.

001 INDICATE ANY WORK LIMITATIONS YOU HAVE SINCE THE ACCIDENT

	NONE 002	DISCOMFORT 020	PAINFUL 038	UNABLE 056	(Describe Where You Feel Pain or Discomfort)
SITTING.....	003[]	021[]	039[]	057[]	074 _____
STANDING.....	004[]	022[]	040[]	058[]	075 _____
WALKING.....	005[]	023[]	041[]	059[]	076 _____
BENDING.....	006[]	024[]	042[]	060[]	077 _____
TWISTING.....	007[]	025[]	043[]	061[]	078 _____
SQUATTING....	008[]	026[]	044[]	062[]	079 _____
CRAWLING.....	009[]	027[]	045[]	063[]	080 _____
CLIMBING.....	010[]	028[]	046[]	064[]	081 _____
REACH UP.....	011[]	029[]	047[]	065[]	082 _____
KNEELING.....	012[]	030[]	048[]	066[]	083 _____
BALANCING....	013[]	031[]	049[]	067[]	084 _____
PUSHING.....	014[]	032[]	050[]	068[]	085 _____
PULLING.....	015[]	033[]	051[]	069[]	086 _____
DRIVING.....	016[]	034[]	052[]	070[]	087 _____
TYPING.....	017[]	035[]	053[]	071[]	088 _____
READING.....	018[]	036[]	054[]	072[]	089 _____
OTHER.....	019[]	037[]	055[]	073[]	090 _____

095 I Could Lift or Carry _____ Lbs. Without Problem Before The Accident.
 After The Accident I Can Lift or Carry: (Mark Maximum Amount In Each Column.)

	<u>OK</u>	<u>DISCOMFORT</u>	<u>PAINFUL</u>	<u>UNABLE</u>
UP to 10 pounds	096[]	102[]	108[]	114[]
11 to 24 pounds	097[]	103[]	109[]	115[]
25 to 34 pounds	098[]	104[]	110[]	116[]
35 to 50 pounds	099[]	105[]	111[]	117[]
51 to 74 pounds	100[]	106[]	112[]	118[]
75 to 100 pounds	101[]	107[]	113[]	119[]

(Describe Where you
Feel Pain or Discomfort)

	OK	DISCOMFORT	PAINFUL	UNABLE	
	123	137	151	165	
DRIVING.....	124[]	138[]	152[]	166[]	179 _____
SHOPPING.....	125[]	139[]	153[]	167[]	180 _____
VACUUMING.....	126[]	140[]	154[]	168[]	181 _____
MOPPING.....	127[]	141[]	155[]	169[]	182 _____
WASHING CLOTHES	128[]	142[]	156[]	170[]	183 _____
WASHING DISHES..	129[]	143[]	157[]	171[]	184 _____
GENERAL CLEANING	130[]	144[]	158[]	172[]	185 _____
COOKING.....	131[]	145[]	159[]	173[]	186 _____
IRONING.....	132[]	146[]	160[]	174[]	187 _____
LAWN WORK.....	133[]	147[]	161[]	175[]	188 _____
SEWING.....	134[]	148[]	162[]	176[]	189 _____
CHILD CARE.....	135[]	149[]	163[]	177[]	190 _____
_____	136[]	150[]	164[]	178[]	191 _____

196 RECREATIONAL ACTIVITIES YOU PARTICIPATED IN AFFECTED BY ACCIDENT ARE:

	OK	DISCOMFORT	PAINFUL	UNABLE
	197	217	237	257
WALKING.....	198[]	218[]	238[]	258[]
BICYCLING.....	199[]	219[]	239[]	259[]
GOLF.....	200[]	220[]	240[]	260[]
TENNIS.....	201[]	221[]	241[]	261[]
RUNNING.....	202[]	222[]	242[]	262[]
SWIMMING.....	203[]	223[]	243[]	263[]
SAILING.....	204[]	224[]	244[]	264[]
BOATING.....	205[]	225[]	245[]	265[]
FISHING.....	206[]	226[]	246[]	266[]
SCUBA DIVING....	207[]	227[]	247[]	267[]
WATER SKIING....	208[]	228[]	248[]	268[]
RACQUET BALL....	209[]	229[]	249[]	269[]
SQUASH.....	210[]	230[]	250[]	270[]
SNOW SKIING....	211[]	231[]	251[]	271[]
HORSEBACK RIDING	212[]	232[]	252[]	272[]
AEROBICS.....	213[]	233[]	253[]	273[]
DANCING.....	214[]	234[]	254[]	274[]
BASEBALL.....	215[]	235[]	255[]	275[]
_____	216[]	236[]	256[]	276[]

280 Please list any additional comments: _____

PATIENT'S SIGNATURE _____ DATE: _____