

Injury Information

Patient Name _____ Date _____

Date of Injury _____ ID# / DOB _____

A. General Injury Information

1. How did the accident occur?
 Auto On-the-Job Other _____

2. Was a police report filed? Yes No
Was a work incident report filed?
 Yes No

3. Describe your injury and how it occurred:

4. Describe how you felt during and immediately after the injury:

Later that same day: _____

The next day: _____

The next week: _____

The next month: _____

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

5. Are your symptoms:
 getting better getting worse no change
What makes them better?

Worse?

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

Have you lost time from work since the injury?
 Yes No

7. What are your work responsibilities?

8. Which work activities are affected by this injury?

Has your work responsibilities changed as a result of the injury?
 Yes No
Explain _____

What other daily activities are affected by this injury?

9. Did you go to the emergency room? Yes No
Were you hospitalized? Yes No

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

10. Have you ever had this type of injury before?
 Yes No
Explain _____

11. Did you have any physical complaints before the injury?
 Yes No
Explain _____

12. Do you have any illnesses or previous injuries that may have been affected by this injury? Yes No
Explain _____

Signature _____

Date _____