

Name _____ Date _____

Date of Loss/Onset (Accident): _____ Claim Number: _____

Describe Accident:

Specifics of Accident (Mark each that applies to the accident):

Job or Work Related injury () Yes () No

Your were the [] Driver [] Passenger
Sitting [] Front seat [] Back seat

Impending Collision [] Braced [] Not braced
Head Did [] Strike Object [] Not strike Object
Did you experience [] Shock
[] Flash of Light Seen Upon Impact
[] Air bag Deployed

Immediately Following the Accident

[] Ambulance – Paramedics Called
[] Treated at Scene
[] Transported to Hospital by Ambulance
[] Went to Hospital on his/her Own
[] Diagnostics Performed at Hospital
[] Medication Prescribed
[] Treatment at Hospital
[] Follow-up Recommended

Time Loss

[] NO time loss from work due to injury. I am currently working with No limitations.

[] NO time loss form work due to injury BUT I do have limitations*.

[] I have experienced time loss from work due to injury. Indicate number of days, weeks, etc

[] N/A

*Describe Limitations: _____

Mechanism of Injury

Were you surprised by the impact? __Yes __No

In relation to the back of your head, was your headrest set: __Low __Middle __High __None

Where was your head facing at the time of impact? __Left __Forward __Right __Unknown

Were you leaning forward at the time of impact? __Yes __No

Were you wearing a seatbelt/harness? __Yes __No

Were you rendered unconscious as a result of the accident? __Yes __No

Did you feel pain immediately after the accident? __Yes __No

Year and type of vehicle were you in? _____

Size of your vehicle? __Small __Mid __Large __Unknown

Year and type of other vehicle involved in the accident? _____

Size of other vehicle? __Small __Mid __Large __Unknown

What was the approximate speed of your vehicle when the accident occurred? _____

What was the approximate speed of the other vehicle when the accident occurred? _____

Name _____ Date _____

Social History

- Single
- Married
- Divorced
- Number of Children: _____
- Smoker
- Non-Smoker
- Drinks Alcohol
- Does not drink Alcohol
- Takes Drugs
- Does not take Drugs

List your Hobbies & Exercise Activities

Occupational History

Your Employer _____

Job Title _____

- Are your Job Duties Physically demanding for you? Yes No
- Have you had any disability time? Yes No
- If you are currently working which are you performing?
 - Regular Duties
 - Limited – Light Duties

What is your current job satisfaction:

- Very Satisfied
- Satisfied
- Dissatisfied
- Very Dissatisfied

Your highest level of education attained? _____

Medical History

I have seen the following physician/practitioners for this condition:

- Chiropractor (Name): _____
- Massage Therapist: _____
- Neurologist: _____
- Orthopedist: _____
- Physical Therapist: _____
- Physician: _____
- Psychiatrist/Psychologist: _____
- Other: _____

Do you feel you are troubled with:

- Anxiety
- depression
- irritability

Current medications I am taking:

List the treatments you have had for this condition.

- Ice
- Heat/Ultrasound
- Electrical Stimulation
- Exercises
- Gravity Inversion – Traction
- Bed Rest
- Chiropractic
- Osteopathy
- Injections
- Acupuncture
- Naturopathy
- Massage

Past Surgeries:

Past Hospitalizations:

List previous back, neck and musculoskeletal problems:

Name _____ Date _____

List the types of Diagnostic Testing that has been for this condition:

- X-rays
- CT Scan
- Myelogram
- MRI
- Discogram
- Bone Scan
- EMG

Females – Mark if have the following:

- Vaginal bleeding other than period
- Pap smear within last two years
- Painful menstrual periods
- Back pain with menstrual periods
- Other menstrual problems

Mark if you have had any of the following symptoms in the past 5 years:

- | | |
|--|--|
| <input type="checkbox"/> Unexplained fevers | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Stomach pain |
| <input type="checkbox"/> Weight loss of 10 lbs or more | <input type="checkbox"/> Change in bowel habits |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Persistent diarrhea |
| <input type="checkbox"/> Excessive fatigue | <input type="checkbox"/> Excessive constipation |
| <input type="checkbox"/> Problems with depression | <input type="checkbox"/> Dark black stools |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Blood in stools |
| <input type="checkbox"/> Unusual stress at work | <input type="checkbox"/> Pain-burning when urinating |
| <input type="checkbox"/> Unusual stress at home | <input type="checkbox"/> Difficulty urinating – start / stop |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Need to urinate more at night |
| <input type="checkbox"/> Lumps in neck, armpit or groin | <input type="checkbox"/> Morning stiffness |
| <input type="checkbox"/> Chest pain or tightness | <input type="checkbox"/> Persistent eye redness |
| <input type="checkbox"/> Persistent or unusual cough | <input type="checkbox"/> Muscle tenderness |
| <input type="checkbox"/> Trouble breathing with exercise | <input type="checkbox"/> Dry eyes or mouth |
| <input type="checkbox"/> Trouble breathing lying flat | <input type="checkbox"/> Skin rashes |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Joint pain or swelling |