

PATIENT CONDITION

Were you unconscious immediately after the accident? Yes No If yes, for how long? _____

Please describe how you felt immediately after the accident:

TREATMENT

Did you go to the hospital? Yes No

When did you go? Immediately after accident Next day 2 days or more after the accident

How did you get to the hospital? Ambulance Private transportation

Name of hospital _____

Diagnosis _____

Treatment received _____

X-rays taken _____

SYMPTOMS / INJURIES

Have you been able to work since this injury? Yes No How many days have you missed? _____

Prior to the injury were you able to work on an equal basis with others your age? _____

If you have had any of the following symptoms since your injury, please check:

- | | | |
|--|---|--|
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Feet/toe numbness | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Hand/finger numbness | <input type="checkbox"/> Neck stiff |
| <input type="checkbox"/> Back stiffness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sleep difficulty |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Ear buzzing | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Ear ringing | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Vision blurred |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nausea | |

Is this condition getting progressively worse? Yes No Unknown

Where do you continue to have pain, numbness, or tingling? _____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

- | | | | |
|--|------------------------------------|------------------------------------|-----------------------------------|
| Type of pain: <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Shooting | <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Cramps | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Swelling | <input type="checkbox"/> Other |

How often do you have this pain?

Is it constant or does it come and go?

Does it interfere with your: Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Bending Standing
 Lying down Walking

I certify that the above information is correct to the best of my knowledge.

Patient signature _____ Date _____