

Patient Name _____ Date _____

Date of Injury _____ Insurance ID# _____

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?

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? _____

8. 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.

9. 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 _____

Signature _____ Date _____