ACCIDENT INFORMATION

Name: _____ Today's Date ___/___/___

Date of Accident: _____ Time of Accident: _____

Location of Accident: _____

Please explain how the accident happened: _____

_____

Indicate the symptoms that are a result of this accident:

❑ Dizziness	❑ Difficulty sleeping	❑ Jaw problems	❑ Nausea
❑ Memory loss	❑ Irritability	❑ Arms/shoulder pain	❑ Back pain
❑ Headaches	❑ Fatigue	❑ Numb Hands/Fingers	❑ Low back pain
❑ Blurred vision	❑ Tension	❑ Chest pain	❑ Back stiffness
❑ Buzzing in ear	❑ Neck pain	❑ Shortness of breath	❑ Leg pain
❑ Ear ringing	❑ Neck stiff	❑ Stomach upset	❑ Numb Feet/Toes

❑ Other _____

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
		(Even if only sometimes)	
Lying on back	❑	❑	❑
Lying on side	❑	❑	❑
Lying on stomach	❑	❑	❑
Sitting	❑	❑	❑
Standing	❑	❑	❑
Lovemaking	❑	❑	❑
Walking	❑	❑	❑
Running	❑	❑	❑
Sports	❑	❑	❑
Working	❑	❑	❑
Lifting	❑	❑	❑
Bending	❑	❑	❑
Kneeling	❑	❑	❑
Pulling	❑	❑	❑
Reaching	❑	❑	❑

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal work day? _____
Please indicate ❑ your daily job duties and any activities which you are occasionally asked to perform.

❑ Standing	❑ Driving	❑ Operating equipment
❑ Sitting	❑ Twisting	❑ Work with arms above head
❑ Walking	❑ Crawling	❑ Typing
❑ Lifting	❑ Bending	❑ Stooping

❑ Other _____

What positions can you work in with minimum physical effort and for how long?
_____ ❑ N/A

Prior to the injury were you capable of working on an equal basis with others your age? _____
Do you work with others who can help you with any heavy lift? _____
While in recovery, is there any light duty work you could request? _____