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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?
____
____
Have 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 ____________

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