Mechanism of Injury:

The injury was due to: _____ Date of accident: _____

FOR WORKMAN'S COMPENSATION-RELATED VISITS ONLY:

How did the injury occur? Choose all that apply.

- ☐ Bending
- ☐ Carrying
- ☐ Climbing
- ☐ Crawling
- ☐ Driving (driver)
- ☐ Driving (passenger)
- ☐ Job activity
- ☐ Jumping
- ☐ Kneeling
- ☐ Raising arm(s) above shoulder(s)
- ☐ Repetitive motion
- ☐ Running
- ☐ Sitting
- ☐ Squatting
- ☐ Standing
- ☐ Standing from a seated position
- ☐ Traveling (public transportation)
- ☐ Turning
- ☐ Twisting
- ☐ Typing
- ☐ Using computer
- ☐ Walking
- ☐ OTHER

FOR PEDESTRIAN ACCIDENTS ONLY:

As a pedestrian, what were you (or was the patient) doing at the time of the accident? _____

FOR AUTO ACCIDENTS ONLY:

Were you (or was the patient) wearing a seatbelt? ◯ Yes ◯ No ◯ Don't know Did the airbag deploy? ◯ Yes ◯ No

Where in the vehicle were you (or was the patient) when the accident happened? _____

What interior vehicle part did you (or the patient) come into contact with? Choose all that apply.

- ☐ No interior parts were contacted at time of accident
- ☐ Airbag
- ☐ Armrest
- ☐ Dashboard
- ☐ Door
- ☐ Flying object(s) inside vehicle
- ☐ Headrest
- ☐ Seat
- ☐ Steering wheel
- ☐ Window
- ☐ Windshield

FOR MOTORCYCLE/BICYCLE ACCIDENTS ONLY:

Where on the vehichle were you (or was the patient) when the accident happened? ◯ Operator ◯ Passenger

What type of protection did you (or did the patient) have? Choose all that apply.

- ☐ Bicycle helmet
- ☐ Motorcycle Helmet- full face
- ☐ Motorcycle Helmet- open face
- ☐ Motorcycle Helmet- half helmet
- ☐ Protective eyewear
- ☐ Leathers
- ☐ Gloves
- ☐ Boots
- ☐ No protective wear
- ☐ OTHER

What did you (or the patient) come into contact with at the time of the collision? _____

Where were you (or was the patient) looking at the time of impact? _____

Did you (or the patient) come in contact with anything at the time of the collision? ◯ Yes ◯ No ◯ Don't know

What part of your (or the patient's) body made contact? Choose all that apply.

- ☐ None made contact
- ☐ Back of head/neck
- ☐ Front of head
- ☐ Left arm
- ☐ Left chest/flank
- ☐ Left foot
- ☐ Left head
- ☐ Left knee
- ☐ Left leg
- ☐ Left shoulder
- ☐ Right arm
- ☐ Right chest/flank
- ☐ Right foot
- ☐ Right head
- ☐ Right knee
- ☐ Right leg
- ☐ Right shoulder
- ☐ OTHER

Did you (or the patient) receive an injury to the head? ◯ Yes ◯ No Did you (or the patient) lose consciousness? ◯ Yes ◯ No

What part of your (or the patient's) vehicle was impacted? Choose all that apply.

- ☐ Front right
- ☐ Front left
- ☐ Front head on
- ☐ Rear right
- ☐ Rear left
- ☐ Rear end
- ☐ Right side (passenger's side)
- ☐ Left side (driver's side)
- ☐ Unknown

In what direction was your (or the patient's) vehicle moving? _____

What was the estimated speed of your (or the patient's) vehicle? _____

What was the extent of the damage to your (or the patient's) vehicle? _____

What was the extent of the damage to the other vehicle? _____

In what direction was the other vehicle moving? _____

Mechanism of Injury (2):

What was the estimated speed of the other vehicle? _____

Was your (or the patient's) vehicle towed from the scene? ◯ Yes ◯ No Did police arrive at the scene? ◯ Yes ◯ No

Did Emergency Medical Services arrive at the scene? ◯ Yes ◯ No Was an accident report taken? ◯ Yes ◯ No

Were you (or was the patient) transported to a medical facility (ER or hospital)? _____

Have you (or has the patient) received any treatment since the accident? Choose all that apply.

- ☐ Admitted
- ☐ Examination was performed
- ☐ Home treatment with cold
- ☐ Home treatment with heat
- ☐ Home treatment with over-the-counter medication
- ☐ Home treatment with rest
- ☐ Medication was prescribed
- ☐ No treatment since accident
- ☐ Physical therapy
- ☐ Referred for further evaluation and treatment
- ☐ Referred to a chiropractor
- ☐ Referred to a neurologists
- ☐ Referred to orthopedists
- ☐ Referred to primary care provider
- ☐ Released
- ☐ Released that day
- ☐ Surgery
- ☐ X-rays were completed
- ☐ OTHER

What was the location of symptoms felt at the time of the accident? Choose all that apply.

Head: ☐ Front of head ☐ Back of head ☐ Right side of head ☐ Left side of head

Neck: ☐ Front of neck ☐ Back of neck ☐ Right side of neck ☐ Left side of neck

Back: ☐ Right mid back ☐ Left mid back ☐ Central mid back ☐ Right low back ☐ Left low back ☐ Central low back

Trunk: ☐ Abdomen ☐ Chest ☐ Front of ribs ☐ Back of ribs ☐ Right side of ribs ☐ Left side of ribs

Upper Extremity:	☐ Front of right upper extremity	☐ Rear of right upper extremity	☐ Front of left upper extremity	☐ Rear of left upper extremity
	☐ Front of right shoulder	☐ Rear of right shoulder	☐ Front of left shoulder	☐ Rear of left shoulder
	☐ Front of right upper arm	☐ Rear of right upper arm	☐ Front of left upper arm	☐ Rear of left upper arm
	☐ Front of right elbow	☐ Rear of right elbow	☐ Front of left elbow	☐ Rear of left elbow
	☐ Front of right wrist	☐ Rear of right wrist	☐ Front of left wrist	☐ Rear of left wrist
	☐ Front of right hand	☐ Rear of right hand	☐ Front of left hand	☐ Rear of left hand
Lower Extremity:	☐ Front of right lower extremity	☐ Rear of right lower extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right hip	☐ Rear of right hip	☐ Front of left hip	☐ Rear of left hip
	☐ Front of right thigh	☐ Rear of right thigh	☐ Front of left thigh	☐ Rear of left thigh
	☐ Front of right knee	☐ Rear of right knee	☐ Front of left knee	☐ Rear of left knee
	☐ Front of right leg	☐ Rear of right leg	☐ Front of left leg	☐ Rear of left leg
	☐ Front of right ankle	☐ Rear of right ankle	☐ Front of left ankle	☐ Rear of left ankle
	☐ Top of right foot	☐ Bottom of right foot	☐ Right side of right foot	☐ Left side of right foot
	☐ Top of left foot	☐ Bottom of left foot	☐ Right side of left foot	☐ Left side of left foot
	☐ OTHER			

Describe the discomfort felt at the time of the accident. Choose all that apply.

- ☐ Aching ☐ Burning ☐ Deep ☐ Diffuse ☐ Dull ☐ Heavy ☐ Numbness ☐ Pulling
- ☐ Sharp ☐ Shock like ☐ Shooting ☐ Stiffness ☐ Throbbing ☐ Tightness ☐ Tingling ☐ OTHER

Are there any additional symptoms which appeared since the accident happened? Choose all that apply.

- ☐ None ☐ Anxiety ☐ Breathing difficulty ☐ Chest pain ☐ Depression
- ☐ Disbelief ☐ Dizziness ☐ Exhaustion ☐ Facial pain ☐ Genital pain
- ☐ Gluteal pain ☐ Headaches ☐ Irritability ☐ Loss of appetite ☐ Low energy
- ☐ Muscle spasm ☐ Numbness and tingling ☐ Rib pain ☐ Shock ☐ Sleeping difficulty
- ☐ Soreness ☐ Stomach pain ☐ Stress ☐ Stunned ☐ Tightness
- ☐ Tiredness ☐ OTHER

Mechanism of Injury (3):

Describe the status of your symptoms since the accident. Choose all that apply.

- ☐ Deteriorated daily functioning at home/work
- ☐ Disappeared
- ☐ Elicited less stiffness
- ☐ Elicited more stiffness
- ☐ Elicited less pain
- ☐ Elicited more pain
- ☐ Exacerbated
- ☐ Improved
- ☐ Improved daily functioning at home/work
- ☐ Lessened
- ☐ Shown no change in daily functioning at home/work
- ☐ Somewhat resolved
- ☐ Stayed the same
- ☐ Worsened
- ☐ Worsened quality of life
- ☐ OTHER

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