Manual Therapist

INJURY INFORMATION

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 _____

B. Motor Vehicle Accident Information

1. Did the police arrive at the accident?
   ☐ Yes ☐ No
2. How was your vehicle hit?
   ☐ Rear end ☐ Head on ☐ Side swipe
   OR Did your vehicle hit another vehicle/object?
   ☐ Rear end ☐ Head on ☐ Side swipe
   If you were hit from behind, was your vehicle pushed forward upon impact?
   ☐ Yes ☐ No If yes, how much?
   _____
   Did your vehicle hit anything else after the initial impact? ☐ Yes ☐ No
   Explain _____
   _____
   _____
   _____
3. Were you at a stop or moving at the time of impact? ☐ Stopped ☐ Moving
   If you were stopped, was your foot on the brake? ☐ Yes ☐ No
   If you were moving, were you:
   ☐ Increasing speed
   ☐ Decreasing speed
   ☐ Traveling at a steady speed
   Was the other vehicle moving at the time of impact? ☐ Yes ☐ No
   If yes, was it: ☐ Increasing speed
   ☐ Decreasing speed ☐ Traveling at a steady speed
4. Where were you seated in the vehicle?
   _____
   _____
   _____
5. Which way was your head facing upon impact?
   _____
   _____
   _____
6. Were you aware of the approaching vehicle or did the impact catch you by surprise?
   ☐ Aware ☐ Surprise
7. Did you lose consciousness?
   ☐ Yes ☐ No
8. Were you wearing a seat belt? ☐ No
   ☐ Lap belt ☐ Shoulder harness ☐ Both
9. Is your vehicle equipped with an airbag?
   ☐ Yes ☐ No
   Did it activate? ☐ Yes ☐ No
10. Is the top of your head rest:
    ☐ Above your head ☐ Below your head
    Does your head touch the head rest?
    ☐ Yes ☐ No
    If no, how far in front of the head rest is your head?
    _____
11. What were the road conditions?
    ☐ Wet ☐ Dry ☐ Icy ☐ Oily
12. What type of vehicle were you in? (make, model, year)
    _____
    What type of vehicle hit you? (make, model, year)
    _____
13. Did any part of your body come into contact with the vehicle? ☐ Yes ☐ No
    Explain _____
    _____
    _____
    _____
    Did any parts of the vehicle break?
    ☐ Yes ☐ No
    Explain _____
    _____
    _____
    _____
14. Check all of the following symptoms that you have experienced since the accident:
    ☐ Loss of memory _____
    ☐ Loss of balance _____
    ☐ Visual disturbances _____
    ☐ Hearing difficulties _____
    ☐ Difficulty breathing _____
    ☐ Sleep disturbances _____
15. Anything else you want to tell me about the accident or how you feel?
    _____
    _____
    _____

Patient Signature _____ Date _____