

**ACCIDENTAL INJURY FORM**

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Date of accident: \_\_\_\_\_ Hour: \_\_\_\_\_ AM/PM Location: \_\_\_\_\_  
 Type of accident: Work Related \_\_\_\_\_ Traffic Related \_\_\_\_\_ Other: \_\_\_\_\_  
 List all other health care practitioners seen for this injury? \_\_\_\_\_

**WORK RELATED ACCIDENT: (Include full details, drawings, etc. on the reverse side)**

Describe your accident including cause/s and surrounding circumstances below:  
 Employer: \_\_\_\_\_ Type of Business: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Was accident reported to supervisor and/or employer? Yes \_\_\_\_\_ No \_\_\_\_\_ Name: \_\_\_\_\_  
 Has a worker's compensation claim been filed? Yes \_\_\_\_\_ No \_\_\_\_\_ Claim#: \_\_\_\_\_  
 Was any equipment, machinery, and/or object related to the accident? Yes \_\_\_\_\_ No \_\_\_\_\_ What Kind? \_\_\_\_\_

**TRAFFIC RELATED ACCIDENT: (Include full details, drawings, etc. on the reverse side)**

Describe your accident including cause/s and surrounding circumstances below:  
 What kind of vehicles were involved? Yours: \_\_\_\_\_ Other(s): \_\_\_\_\_  
 Were you the: Driver \_\_\_\_\_ Passenger \_\_\_\_\_ Pedestrian \_\_\_\_\_? Were you wearing a seat belt? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Was anyone else in the vehicle with you? Yes \_\_\_\_\_ No \_\_\_\_\_ Who? \_\_\_\_\_  
 Was your vehicle moving when the accident occurred? Yes \_\_\_\_\_ No \_\_\_\_\_ How fast? \_\_\_\_\_ MPH  
 Did another vehicle/s hit your vehicle? Yes \_\_\_\_\_ No \_\_\_\_\_ How fast were they going? \_\_\_\_\_ MPH  
 Were you struck from: Behind \_\_\_\_\_ Right Side \_\_\_\_\_ Left Side \_\_\_\_\_ Front \_\_\_\_\_ Other: \_\_\_\_\_?  
 Did your vehicle hit other vehicle/s? Yes \_\_\_\_\_ No \_\_\_\_\_ Where? \_\_\_\_\_  
 Was a police report filed? Yes \_\_\_\_\_ No \_\_\_\_\_ Were traffic citations issued? Yes \_\_\_\_\_ No \_\_\_\_\_ To Whom? \_\_\_\_\_  
 Did Emergency Personnel come? Yes \_\_\_\_\_ No \_\_\_\_\_ Did your air bags deploy? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Did you require post-accident hospitalization? Yes \_\_\_\_\_ No \_\_\_\_\_ Where? \_\_\_\_\_  
 What were the road and weather conditions? \_\_\_\_\_

**SYMPTOMS AFTER ACCIDENT: (Check all that apply) (Include further details of your symptoms on the reverse side)**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Headache / Base Of Skull Pain | <input type="checkbox"/> Hip Pain                | <input type="checkbox"/> Anxiety             |
| <input type="checkbox"/> Head Seems Too Heavy          | <input type="checkbox"/> Pins/Needles In Legs    | <input type="checkbox"/> Fatigue             |
| <input type="checkbox"/> Head/Shoulders Tired & Heavy  | <input type="checkbox"/> Numbness _____          | <input type="checkbox"/> Insomnia            |
| <input type="checkbox"/> Mental Dullness               | <input type="checkbox"/> Chest Pain              | <input type="checkbox"/> Face Flushed        |
| <input type="checkbox"/> Loss Of Memory                | <input type="checkbox"/> Shortness Of Breath     | <input type="checkbox"/> Feet Cold           |
| <input type="checkbox"/> Equilibrium Problems          | <input type="checkbox"/> Eye Strain              | <input type="checkbox"/> Hands Cold          |
| <input type="checkbox"/> Dizziness                     | <input type="checkbox"/> Pain Behind Eyes        | <input type="checkbox"/> Excess Perspiration |
| <input type="checkbox"/> Fainting                      | <input type="checkbox"/> Eyes Sensitive To Light | <input type="checkbox"/> Digestive Disorders |
| <input type="checkbox"/> Tremors                       | <input type="checkbox"/> Face Pain               | <input type="checkbox"/> Nausea              |
| <input type="checkbox"/> Neck Pain                     | <input type="checkbox"/> Loss Of Smell           | <input type="checkbox"/> Vomiting            |
| <input type="checkbox"/> Neck Stiffness                | <input type="checkbox"/> Ears Buzzing/Ringing    | <input type="checkbox"/> Diarrhea            |
| <input type="checkbox"/> Neck Motion Restricted        | <input type="checkbox"/> Double Vision           | <input type="checkbox"/> Swollen _____       |
| <input type="checkbox"/> Back Pain                     | <input type="checkbox"/> Loss Of Taste           | <input type="checkbox"/> Fever               |
| <input type="checkbox"/> Back Stiffness                | <input type="checkbox"/> Sinus Trouble           | <input type="checkbox"/> Cold Sweats         |
| <input type="checkbox"/> Back Motion Restricted        | <input type="checkbox"/> Nervousness             | <input type="checkbox"/> Difficulty Sitting  |
| <input type="checkbox"/> Shoulder Pain                 | <input type="checkbox"/> Irritability            | <input type="checkbox"/> Difficulty Standing |
| <input type="checkbox"/> Pins/Needles In Arms          | <input type="checkbox"/> Tension                 | <input type="checkbox"/> Other _____         |

**ATTORNEY:** Name: \_\_\_\_\_ Ph#: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**DATE:** \_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_



Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## **Neck & Upper Back Pain Index**

In each section below, please circle the ONE NUMBER which most closely describes your problem right now.

### **Pain Intensity**

0. I have no pain at the moment.
1. The pain is very mild at the moment.
2. The pain comes and goes and is moderate.
3. The pain is fairly severe at the moment.
4. The pain is very severe at the moment.
5. The pain is the worst imaginable at the moment.

### **Personal Care**

0. I can look after myself normally without causing extra pain.
1. I can look after myself normally but it causes extra pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help but I manage most of my personal care.
4. I need help every day in most aspects of self care.
5. I do not get dressed, I wash with difficulty and stay in bed.

### **Sleeping**

0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hour sleepless).
2. My sleep is mildly disturbed (1-2 hours sleepless).
3. My sleep is moderately disturbed (2-3 hours sleepless).
4. My sleep is greatly disturbed (3-5 hours sleepless).
5. My sleep is completely disturbed (5-7 hours sleepless).

### **Lifting**

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it causes extra pain.
2. I can't lift heavy weights unless they're conveniently positioned, (e.g., on a table).
3. I can't lift medium weights unless they're conveniently positioned, (e.g., on a table).
4. I can lift only very light weights
5. I cannot lift or carry anything at all.

### **Reading**

0. I can read as much as I want with no neck pain.
1. I can read as much as I want with slight neck pain.
2. I can read as much as I want with moderate neck pain.
3. I cannot read as much as I want because of moderate neck pain.
4. I can hardly read at all because of severe neck pain.
5. I cannot read at all because of neck pain.

### **Driving**

0. I can drive my car without any neck pain.
1. I can drive my car as long as I want with slight neck pain.
2. I can drive my car as long as I want with moderate neck pain.
3. I cannot drive my car as long as I want because of moderate neck pain.
4. I can hardly drive at all because of severe neck pain.
5. I cannot drive my car at all because of neck pain.

### **Concentration**

0. I can concentrate fully when I want with no difficulty.
1. I can concentrate fully when I want with slight difficulty.
2. I have a fair degree of difficulty concentrating when I want.
3. I have a lot of difficulty concentrating when I want.
4. I have a great deal of difficulty concentrating when I want.
5. I cannot concentrate at all.

### **Recreation**

0. I am able to engage in all my recreation activities without neck pain.
1. I am able to engage in all my usual recreation activities with some neck pain.
2. I am able to engage in most of my usual recreation activities with moderate neck pain.
3. I am only able to engage in a few of my usual recreation activities due to neck pain.
4. I can hardly do any recreation activities because of neck pain.
5. I cannot do any recreation activities at all.

### **Work**

0. I can do as much work as I want.
1. I can only do my usual work but no more.
2. I can only do most of my usual work but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I cannot do any work at all.

### **Headaches**

0. I have no headaches at all.
1. I have slight headaches which come infrequently.
2. I have moderate headaches which come infrequently.
3. I have moderate headaches which come frequently.
4. I have severe headaches which come frequently.
5. I have headaches almost all the time.

Index Score = [Sum of all statements selected / ( # of sections with a statement selected x 5 )] x 100

**NECK PAIN INDEX SCORE:** \_\_\_\_\_

0%-20% = Slight Disability, 21%-40% = Mild Disability, 41%-60% = Moderate Disability, 61%-80% = Severe Disability, 81%-100% = Complete Disability

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Mid & Low Back Pain Index

In each section below, please circle the ONE NUMBER which most closely describes your problem right now.

### Pain Intensity

0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

### Personal Care

0. I do not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it hurts.
2. Washing and dressing increases the pain but I manage not to change how I do it.
3. Washing and dressing increases the pain and I find it necessary to change how I do it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

### Sleeping

0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal sleep is reduced by less than 25%.
3. Because of pain my normal sleep is reduced by less than 50%.
4. Because of pain my normal sleep is reduced by less than 75%.
5. Pain prevents me from sleeping at all.

### Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it causes extra pain.
2. I can't lift heavy weights unless they're conveniently positioned, (e.g., on a table).
3. I can't lift medium weights unless they're conveniently positioned, (e.g., on a table).
4. I can lift only very light weights
5. I cannot lift or carry anything at all.

### Sitting

0. I can sit in any chair as long as I like.
1. I can only sit in my favorite chair as long as I like.
2. Pain prevents me from sitting more than an hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

### Traveling

0. I get no pain while traveling.
1. I get some pain while traveling but my usual forms of travel do not make it worse.
2. I get extra pain while traveling but it doesn't cause me to seek alternate forms of travel.
3. I get extra pain while traveling which causes me to seek alternate forms of travel.
4. Pain restricts all forms of travel except if it is done while lying down.
5. Pain restricts all forms of travel.

### Standing

0. I can stand as long as I want without pain.
1. I have some pain while standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases pain immediately.

### Social life

0. My social life is normal and gives me no extra pain.
1. My social life is normal but increases the degree of pain.
2. Pain slightly affects my social life by limiting my energetic interests like dancing.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

### Walking

0. I have no pain while walking
1. I have mild pain while walking.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

### Changing degree of pain

0. My pain is rapidly getting better.
1. My pain fluctuates but overall is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better nor worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Index Score = [Sum of all statements selected / ( # of sections with a statement selected x 5 )] x 100

**BACK PAIN INDEX SCORE:** \_\_\_\_\_

0%-20% = Slight Disability, 21%-40% = Mild Disability, 41%-60% = Moderate Disability, 61%-80% = Severe Disability, 81%-100% = Complete Disability