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 _____