ACCIDENT INJURY INFORMATION

Name: _____ **Date:** _____

1. Date of accident: _____

2. Injuries (sustained, incurred): _____

3. On a scale of 1-10, rate the level of pain you are in (specify for multiple areas):

1 2 3 4 5 6 7 8 9 10

(No Pain) (Excruciating Pain)

4. What treatment was done for your injury? _____

_____

5. Did you go to the emergency room/hospital? Yes___ No___ If yes, which hospital? _____

6. Were x-rays or other imaging (CT, MRI) done? Yes___ No___ If yes, please specify: _____

_____

7. Other doctors who treated this condition: _____

8. Currently is your condition aggravated by:

__Coughing __Neck movement __Bending __Walking

__Sneezing __Reaching __Sitting __Standing

__Straining at stool __Lifting __Other: _____

9. Is this condition getting progressively worse? Yes___No___Constant____Comes and goes____

10. Describe the Accident: _____

_____

_____

_____

_____

_____

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