SYMPTOMS FROM ACCIDENT

Did you experience bleeding, cuts or bruises? ☐ Yes ☐ No

If bleeding or cuts, where? _____ If bruises, where? _____

Please describe how you felt: PLEASE BE SPECIFIC

Immediately after the accident: _____

Later that Day / Night: _____

The next day(s): _____

_____

Check symptoms that have been apparent since the accident/injury:

☐	Nervousness	☐	Loss of balance	☐	Sleeping Trouble	☐	Headache	☐	Fainting
☐	Neck Pain/Stiffness	☐	Loss of smell	☐	Toe Numbness	☐	Anxiety	☐	Seizures
☐	Ringing/buzzing ears	☐	Loss of taste	☐	Finger Numbness	☐	Cold Hands	☐	Cold Feet
☐	Low Back Pain	☐	Loss of memory	☐	Blurred Vision	☐	Chest Pain	☐	Constipation
☐	Eyes- light sensitive	☐	Pins/Needles –Arms	☐	Diarrhea	☐	Fatigue	☐	Depression
☐	Pain behind eyes	☐	Pins/Needles – Legs	☐	Dizziness	☐	Confusion	☐	Disoriented
☐	Shortness of breath	☐	Double Vision	☐	Forgetfulness	☐	Tension	☐	Cold Sweats
☐	Heads seems heavy	☐	Mid back Pain	☐	Face Flushed	☐	Irritability	☐	Fever
☐	Visual Disturbance	☐	Other	☐		☐		☐	

MECHANISM OF INJURY:

Pleases explain the mechanism of the injury (only fill in the sections that apply to you)

FALL

☐ Yes ☐ No Did you hit anything when you fell? If yes, what? _____

☐ Yes ☐ No Were you carrying anything when you fell? If yes, what? _____

How much did it weigh? _____ lbs

☐ Yes ☐ No Did you twist when you fell? If so, to which side? ☐ Left ☐ Right

☐ Yes ☐ No Was the area lighted?

Describe the condition of the area (slippery, graveled, etc) _____

What part of the body did you fall on? _____

How far did you fall ? (In feet) _____

What did you land on? _____

LIFT/PULL

How much did the object weigh? _____ lbs

☐ Yes ☐ No Did you fall after the injury? If yes, how far? _____

☐ Yes ☐ No Did you hit anything when you fell? If yes, what? _____

☐ Yes ☐ No Were you twisting when you were lifting/pulling? If yes, to which side? ☐ Left ☐ Right

How far off the ground did you have the object before the pain started? _____

☐ Yes ☐ No Did you drop the object when the pain started?

☐ Yes ☐ No Did it land on you? Where? _____

Did you lift your ☐ Legs ☐ Back Other _____

BEND

☐ Yes ☐ No Were you lifting when you bent over? If yes, how much did the object weigh? _____ lbs

How far did you bend over? _____

☐ Yes ☐ No Did you fall when the pain started? How far? _____

☐ Yes ☐ No Were you twisting when you bent forward? Toward which side? ☐ Left ☐ Right

☐ Yes ☐ No Did you land on anything? If so, what? _____

WORK STATUS HISTORY:

☐ Yes ☐ No Have you lost time from work as a result of this new injury? If yes, give dates: _____

_____

☐ Yes ☐ No Have you gone back to work? When? _____

If yes, status of work: ☐ Modified ☐ Regular

List restrictions that you have been placed on: _____

If you have gone back to work, list the activities that are:

PAINFUL _____

DIFFICULT _____

☐ Yes ☐ No If you are currently on disability (time loss), do you want to go back to work doing your regular job? If no, why not? _____

☐ Yes ☐ No Are there any problems you have with a fellow employee, supervisor, or manager that needs to be discussed? If yes, please explain: _____