

**Post-Injury (page 2 of 2)**

**Name:** \_\_\_\_\_ **Chart #:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_ **Accident Date:** \_\_\_\_\_

**WHAT HAPPENED IMMEDIATELY AFTER THE ACCIDENT?**

<b>Initial reaction</b> (mark all that apply) <input type="checkbox"/> Confused <input type="checkbox"/> Dazed <input type="checkbox"/> Distressed <input type="checkbox"/> Dizzy <input type="checkbox"/> Frightened <input type="checkbox"/> Light-headed <input type="checkbox"/> Nervous <input type="checkbox"/> Shaken <input type="checkbox"/> Upset <input type="checkbox"/> Weak	<b>After the accident, in which body areas did you experience pain?</b> (mark all that apply) <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Left shoulder <input type="checkbox"/> Right shoulder <input type="checkbox"/> Left arm <input type="checkbox"/> Right arm <input type="checkbox"/> Left elbow <input type="checkbox"/> Right elbow <input type="checkbox"/> Left forearm <input type="checkbox"/> Right forearm <input type="checkbox"/> Left wrist <input type="checkbox"/> Right wrist <input type="checkbox"/> Left hand <input type="checkbox"/> Right hand <input type="checkbox"/> Chest <input type="checkbox"/> Rib cage <input type="checkbox"/> Upper back <input type="checkbox"/> Mid back <input type="checkbox"/> Abdomen <input type="checkbox"/> Lower back <input type="checkbox"/> Left wrist <input type="checkbox"/> Right wrist <input type="checkbox"/> Left hand <input type="checkbox"/> Right hand <input type="checkbox"/> Chest <input type="checkbox"/> Rib cage <input type="checkbox"/> Upper back <input type="checkbox"/> Mid back <input type="checkbox"/> Abdomen <input type="checkbox"/> Lower back <input type="checkbox"/> Pelvis <input type="checkbox"/> Left buttock <input type="checkbox"/> Right buttock <input type="checkbox"/> Left leg <input type="checkbox"/> Right leg <input type="checkbox"/> Left hip <input type="checkbox"/> Right hip <input type="checkbox"/> Left thigh <input type="checkbox"/> Right thigh <input type="checkbox"/> Left knee <input type="checkbox"/> Right knee <input type="checkbox"/> Left shin <input type="checkbox"/> Right shin <input type="checkbox"/> Left ankle <input type="checkbox"/> Right ankle <input type="checkbox"/> Left foot <input type="checkbox"/> Right foot	<b>Did you lose Consciousness?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <b>Any emergency care?</b> <input type="checkbox"/> Bandages <input type="checkbox"/> Bracing <input type="checkbox"/> CPR <input type="checkbox"/> Neck Collar <input type="checkbox"/> Splinting	<b>Destination after injury</b> (choose one) <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Hospital <input type="checkbox"/> Clinic <input type="checkbox"/> Doctor <b>Who drove you?</b> <input type="checkbox"/> Self <input type="checkbox"/> Friend <input type="checkbox"/> Ambulance <input type="checkbox"/> Family member
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**Please indicate any lacerations (cuts) resulting from the accident** (mark all that apply)

<input type="checkbox"/> Head	<input type="checkbox"/> Neck	<input type="checkbox"/> Left shoulder	<input type="checkbox"/> Right shoulder	<input type="checkbox"/> Left arm	<input type="checkbox"/> Right arm	<input type="checkbox"/> Left forearm	<input type="checkbox"/> Right forearm	<input type="checkbox"/> Left wrist	<input type="checkbox"/> Right wrist	<input type="checkbox"/> Left hand	<input type="checkbox"/> Right hand	<input type="checkbox"/> Chest	<input type="checkbox"/> Rib cage	<input type="checkbox"/> Upper back	<input type="checkbox"/> Mid back	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Lower back	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Left buttock	<input type="checkbox"/> Right buttock	<input type="checkbox"/> Left leg	<input type="checkbox"/> Right leg	<input type="checkbox"/> Left hip	<input type="checkbox"/> Right hip	<input type="checkbox"/> Left thigh	<input type="checkbox"/> Right thigh	<input type="checkbox"/> Left knee	<input type="checkbox"/> Right knee	<input type="checkbox"/> Left shin	<input type="checkbox"/> Right shin	<input type="checkbox"/> Left ankle	<input type="checkbox"/> Right ankle	<input type="checkbox"/> Left foot	<input type="checkbox"/> Right foot
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**TREATMENTS ADMINISTERED AFTER THE ACCIDENT**

<b>Were you admitted to a hospital?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Name of Hospital/Clinic:</b> _____ <b>Examining Physician:</b> _____ <b>Date of Visit:</b> _____ <b>Date of Discharge:</b> _____
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<b>Were any X-Rays taken?</b> (mark all that apply)		<input type="checkbox"/> Left hand	<input type="checkbox"/> Mid back	<input type="checkbox"/> Right buttock	<input type="checkbox"/> Left thigh	<input type="checkbox"/> Right shin
<input type="checkbox"/> Head	<input type="checkbox"/> Neck	<input type="checkbox"/> Left shoulder	<input type="checkbox"/> Right shoulder	<input type="checkbox"/> Left arm	<input type="checkbox"/> Right arm	<input type="checkbox"/> Left forearm
<input type="checkbox"/> Right forearm	<input type="checkbox"/> Chest	<input type="checkbox"/> Lower back	<input type="checkbox"/> Right leg	<input type="checkbox"/> Left knee	<input type="checkbox"/> Right ankle	<input type="checkbox"/> Left ankle
<input type="checkbox"/> Left elbow	<input type="checkbox"/> Left wrist	<input type="checkbox"/> Rib cage	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Left hip	<input type="checkbox"/> Right knee	<input type="checkbox"/> Left foot
<input type="checkbox"/> Right elbow	<input type="checkbox"/> Right wrist	<input type="checkbox"/> Upper back	<input type="checkbox"/> Left buttock	<input type="checkbox"/> Right hip	<input type="checkbox"/> Left shin	<input type="checkbox"/> Right foot

<b>Were any CAT scans performed?</b> (mark all that apply)		<input type="checkbox"/> Left hand	<input type="checkbox"/> Mid back	<input type="checkbox"/> Right buttock	<input type="checkbox"/> Left thigh	<input type="checkbox"/> Right shin
<input type="checkbox"/> Head	<input type="checkbox"/> Neck	<input type="checkbox"/> Left shoulder	<input type="checkbox"/> Right shoulder	<input type="checkbox"/> Left arm	<input type="checkbox"/> Right arm	<input type="checkbox"/> Left forearm
<input type="checkbox"/> Right forearm	<input type="checkbox"/> Chest	<input type="checkbox"/> Lower back	<input type="checkbox"/> Right leg	<input type="checkbox"/> Left knee	<input type="checkbox"/> Right ankle	<input type="checkbox"/> Left ankle
<input type="checkbox"/> Left elbow	<input type="checkbox"/> Left wrist	<input type="checkbox"/> Rib cage	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Left hip	<input type="checkbox"/> Right knee	<input type="checkbox"/> Left foot
<input type="checkbox"/> Right elbow	<input type="checkbox"/> Right wrist	<input type="checkbox"/> Upper back	<input type="checkbox"/> Left buttock	<input type="checkbox"/> Right hip	<input type="checkbox"/> Left shin	<input type="checkbox"/> Right foot

<b>Were any MRI scans performed?</b> (mark all that apply)		<input type="checkbox"/> Left hand	<input type="checkbox"/> Mid back	<input type="checkbox"/> Right buttock	<input type="checkbox"/> Left thigh	<input type="checkbox"/> Right shin
<input type="checkbox"/> Head	<input type="checkbox"/> Neck	<input type="checkbox"/> Left shoulder	<input type="checkbox"/> Right shoulder	<input type="checkbox"/> Left arm	<input type="checkbox"/> Right arm	<input type="checkbox"/> Left forearm
<input type="checkbox"/> Right forearm	<input type="checkbox"/> Chest	<input type="checkbox"/> Lower back	<input type="checkbox"/> Right leg	<input type="checkbox"/> Left knee	<input type="checkbox"/> Right ankle	<input type="checkbox"/> Left ankle
<input type="checkbox"/> Left elbow	<input type="checkbox"/> Left wrist	<input type="checkbox"/> Rib cage	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Left hip	<input type="checkbox"/> Right knee	<input type="checkbox"/> Left foot
<input type="checkbox"/> Right elbow	<input type="checkbox"/> Right wrist	<input type="checkbox"/> Upper back	<input type="checkbox"/> Left buttock	<input type="checkbox"/> Right hip	<input type="checkbox"/> Left shin	<input type="checkbox"/> Right foot

**Previous diagnosis of this injury:** \_\_\_\_\_

<b>Treatments Administered</b> <input type="checkbox"/> Adjustments <input type="checkbox"/> Bandages <input type="checkbox"/> Brace <input type="checkbox"/> Cast <input type="checkbox"/> Collar <input type="checkbox"/> Hot Packs <input type="checkbox"/> Ice Packs <input type="checkbox"/> Injection <input type="checkbox"/> Splint <input type="checkbox"/> Support <input type="checkbox"/> Surgery <input type="checkbox"/> Muscle Relaxants <input type="checkbox"/> Oral medication <input type="checkbox"/> Sutures <input type="checkbox"/> Topical Antiseptic	<b>Recommendations</b> <input type="checkbox"/> No further care required <input type="checkbox"/> Refer to Plastic Surgeon <input type="checkbox"/> Refer to Chiropractor <input type="checkbox"/> Refer to General Practitioner <input type="checkbox"/> Refer to General Surgeon <input type="checkbox"/> Refer to Internist <input type="checkbox"/> Refer to Neurologist <input type="checkbox"/> Refer to Orthopedist <input type="checkbox"/> Refer to Physical Therapist <input type="checkbox"/> See Physician if symptoms persist <input type="checkbox"/> Time off work <input type="checkbox"/> Undergo observation <input type="checkbox"/> Heat therapy <input type="checkbox"/> Cervical Collar <input type="checkbox"/> Orthopedic shoes <input type="checkbox"/> Rest <input type="checkbox"/> Ice packs	<b>Medications Prescribed</b> <input type="checkbox"/> Antibiotic <input type="checkbox"/> Anti-Inflammatory <input type="checkbox"/> Anxiety medications <input type="checkbox"/> Herbs <input type="checkbox"/> Muscle Relaxants <input type="checkbox"/> Over-the-Counter Medications <input type="checkbox"/> Pain Killers
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