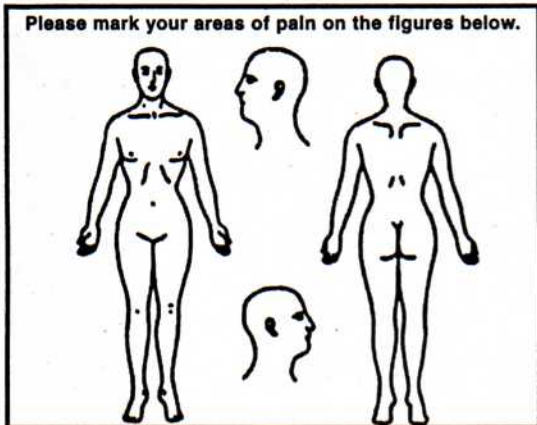


Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Please mark your areas of pain on the figures below.



1. List the conditions that you are most interested in getting corrected.

List in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

2. What functions are you unable to perform or induce pain upon performance? List in order of severity. (Example: sitting, walking, bending, lying, etc.)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Did your complaint begin gradually or suddenly?

Gradually...  Suddenly... About when did it begin? \_\_\_\_\_

Date of injury: \_\_\_\_\_

**Complete this section if your injury began GRADUALLY**

Is your condition... \_\_\_\_\_

What do you believe caused your condition? \_\_\_\_\_

- Getting better  
 Getting worse  
 Remaining the same

**Complete this section if your injury began SUDDENLY**

This injury occurred when I...

Was your injury caused by an auto accident?  Yes  No

- awoke from sleep  
 was bending and stood back up  
 slipped while carrying an object  
 climbed into or out of a vehicle  
 was struck by a falling object  
 was engaged in a physical activity  
 was engaged in a repetitive motion activity

- was involved in an accident  
 coughed or sneezed  
 turned and looked to the side  
 twisted or turned at the waist  
 fell from a height  
 slipped and fell  
 lifted an object

Where were you when the injury occurred?

- outdoors  playing sports  
 at work\*\*  while working  
 home  
 school  
 at a business other than work  
 (store, restaurant...)

When did your pain or symptoms begin?

- During the injury  
 Immediately after the injury  
 Several minutes after the injury  
 Hours after the injury  
 Days after the injury

What type of pain did you feel immediately after the injury?

- Dull ache  Ripping/tearing sensation  
 Squeezing sensation  Deep, boring pain  
 Popping sensation  Shock-like sensation  
 Localized, sharp pain  Pins & Needles sensation  
 Sharp shooting pain  Stabbing pain  
 Burning pain  Numbness

\*\*Was the injury reported to a supervisor?

- Yes  
 No

Describe in detail, the account of your injury: \_\_\_\_\_

**Complete this section if your injury occurred WHILE LIFTING**

Where were you lifting the object from?

- the floor  
 a surface overhead  
 a surface at about waist level

How much did the object weigh?

- <2 pounds  15-20 lbs.  
 2-5 lbs  20-25 lbs  
 5-10 lbs  25-50 lbs  
 10-15 lbs  >50 lbs

How was your position?

- Back was straight  
 Twisted to the left  
 Twisted to the right  
 Bent at the waist

**Complete this section if your injury DUE TO A FALL**

How far did you fall?

- 2- 4 feet  
 4-6 feet  
 6-8 feet  
 more than 8 feet

Did you hit any part of your body during the fall?

- Hand  Left elbow  Left knee  
 Forehead  Right elbow  Right elbow  
 Back  Left wrist/hand  Left ankle  
 Left hip  Right wrist/hand  Right ankle

What surface did you land on?

- Concrete  Ground  
 Pavement  Gravel  
 Stairs  Carpeted surface  
 Hard floor  Against a vehicle  
 Deep water  Shallow water

What part of your body did you land on?

- Head  Left knee  Elbow  Right side  Outstretched arms  Back  
 Feet  Right knee  Shoulder  Left hip  Outstretched left arm  Buttocks  
 Knees  Stomach  Left side  Right hip  Outstretched right arm  Buttocks and back of thighs

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: \_\_\_\_\_