

CAD Injury History Form

General information:

Patient' name: _____

Today's date: _____

Date of injury: _____

Marital status: M S W D

Habits:

Smoke: None Pk/day _____ Years _____

Alcohol: Never Social Light Mod.

Heavy

Employment:

At time of crash: _____

Unemployed

Currently: _____

Unemployed

Due to crash? Yes No

Type of work: Office/clerical Light labor

Moderate labor Heavy labor

Past medical history:

Surgeries (dates and residuals): _____

Fractures (dates and residuals): _____

Serious illness (dates and residuals): _____

Workers' comp. injuries (date, TX, awards,

residuals): _____

Personal Injuries (date, TX, awards, residuals):

Sports or other injuries to head, neck, or back:

Past medical history (cont'd)

Any prior HX of current complaints:

1. _____

2. _____

3. _____

Prior TX by DC for these:

1. _____

2. _____

3. _____

Current Medical history:

Current health problems: None

Current medications taken: None

Injury history. General:

Was the crash on-the-job? Yes No

You were: Driver Front seat passenger

Rear seat passenger Motorcycle operator

Motorcycle passenger Other _____

Vehicle driven by: _____

Your vehicle (year, make, model): _____

Your estimated speed at moment of crash: _____

Stopped Slowing Accelerating

Other vehicle (year, make, model): _____

Time of day: Daylight Dawn Dusk

Dark

Road conditions: Dry Damp Wet

Snow Ice Other _____

Head restraints: None Integral type

Adjustable type: Up Down

Don't know

If adjustable, was the position altered by the crash? Yes No

Was the seat back adjustment altered by the crash? Yes No

Was the seat broken? Yes No

Lap belt: Wearing Not wearing

Don't know

Shoulder belt: None Wearing

Not wearing Don't know

Did air bag deploy? Yes No

If yes, were you struck? Yes No

Body position: Good Forward lean

Other _____

Head position: Forward Left ____°

Right ____° Up ____° Down ____°

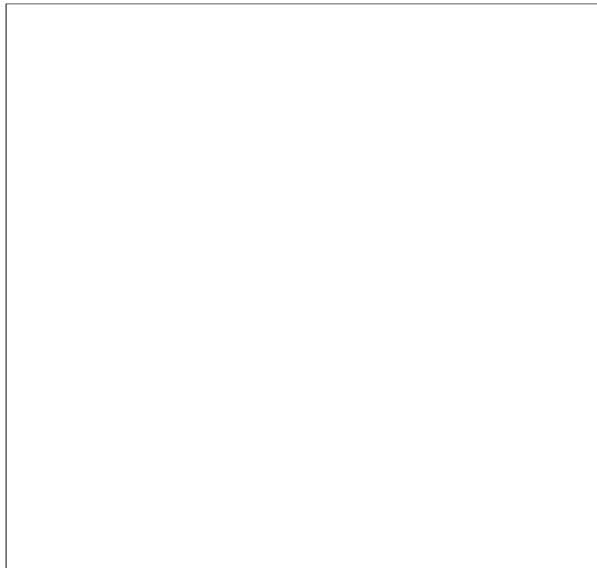
Injury history. General: (cont'd)

Hands: One on wheel Two on wheel
 N/A

Brakes applied? Yes No

Crash description: _____

Crash diagram:



Aware of impending crash? Yes No

During the crash:

Did you strike any parts of the vehicle? Y N

If yes, describe _____

Did vehicle strike any objects after crash?

If yes, describe _____

Wearing hat or glasses? Yes No

If yes, still on after crash? Yes No

Did you lose consciousness? Yes No

If yes, for how long? _____

Estimated property damage to your vehicle:
\$ _____

Estimated damage to other vehicle(s): None

Minimal Moderate Major

Were the police on-scene? Yes No

If yes, was a report made? Yes No

After the crash:

Symptoms: Headache Dizziness Nausea
 Confusion/disorientation Neck pain
 Paresthesia(s)

If yes, where? _____

Extremity pain. If yes, where? _____

Back pain

When did SX first appear? Immediately
(describe which SX) _____ hr afterward

Where did you go after crash? Home

Work Hospital:

Mode of transportation _____

Pvt. doctor: _____

Emergency department:

Radiographs: Yes No

Body parts imaged _____

Results _____

Lab work Yes No _____

Cervical collar Ice

Medications: _____

Other: _____

Follow-up instructions: None _____

Treatment history:

1. Dr.: _____

Specialty: _____ Date first seen: _____

Referred by: _____ TX type: _____

TX frequency: _____ TX duration: _____

Currently treating? Yes No

Any disability? Yes No

If yes, describe: _____

Special tests: _____

Referred to: _____

Did TX help? Yes No

Notes: _____

2. Dr.: _____

Specialty: _____ Date first seen: _____

Referred by: _____ TX type: _____

TX frequency: _____ TX duration: _____

Currently treating? Yes No

Any disability? Yes No

If yes, describe: _____

Special tests: _____

Referred to: _____

Did TX help? Yes No

Notes: _____

Treatment history: (cont'd)

3. Dr.: _____
Specialty: _____ Date first seen: _____
Referred by: _____ TX type: _____
TX frequency: _____ TX duration: _____
Currently treating? Yes No
Any disability? Yes No
If yes, describe: _____
Special tests: _____
Referred to: _____
Did TX help? Yes No
Notes: _____

4. Dr.: _____
Specialty: _____ Date first seen: _____
Referred by: _____ TX type: _____
TX frequency: _____ TX duration: _____
Currently treating? Yes No
Any disability? Yes No
If yes, describe: _____
Special tests: _____
Referred to: _____
Did TX help? Yes No
Notes: _____

5. Dr.: _____
Specialty: _____ Date first seen: _____
Referred by: _____ TX type: _____
TX frequency: _____ TX duration: _____
Currently treating? Yes No
Any disability? Yes No
If yes, describe: _____
Special tests: _____
Referred to: _____
Did TX help? Yes No
Notes: _____

6. Dr.: _____
Specialty: _____ Date first seen: _____
Referred by: _____ TX type: _____
TX frequency: _____ TX duration: _____
Currently treating? Yes No
Any disability? Yes No
If yes, describe: _____
Special tests: _____
Referred to: _____
Did TX help? Yes No
Notes: _____

**Original chief complaints
(if injury was not recent):**

1. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

2. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

3. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

4. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

5. Body part/system: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Radiation: _____
Severity (1-4): _____
Temporal: _____

Current chief complaints:

1. Body part/system: _____

Onset: _____

Provocative: _____

Palliative: _____

Quality: _____

Radiation: _____

Severity (1-4): _____

Temporal: _____

2. Body part/system: _____

Onset: _____

Provocative: _____

Palliative: _____

Quality: _____

Radiation: _____

Severity (1-4): _____

Temporal: _____

3. Body part/system: _____

Onset: _____

Provocative: _____

Palliative: _____

Quality: _____

Radiation: _____

Severity (1-4): _____

Temporal: _____

4. Body part/system: _____

Onset: _____

Provocative: _____

Palliative: _____

Quality: _____

Radiation: _____

Severity (1-4): _____

Temporal: _____

5. Body part/system: _____

Onset: _____

Provocative: _____

Palliative: _____

Quality: _____

Radiation: _____

Severity (1-4): _____

Temporal: _____

Self assessment as of today: % improved (list for separate areas)

Request records:

1. Request radiographs from: _____

2. Request records from: _____

3. Request copy of police report.

Referral:

For: _____

To: _____

Tests to order:

Radiographs: _____

Tomograms: _____

CT: _____

Area(s): _____

MRI: _____

Area(s): _____

MRA: _____

Area(s): _____

Scintigraphy/SPECT: _____

Area(s): _____

Videofluoroscopy: _____

Area(s): _____

EMG/NCV: _____

Root level/nerve(s): _____

SEP: _____

Root level/nerve(s): _____

Other electrodiagnostic test(s): _____

Ultrasound: _____

Area(s): _____

Action taken on this visit:

Exam/TX: _____

Place on disability: _____

Work restriction: _____

Referral: _____

Brace/collar: _____

Home traction device: _____

NEXERCICER: _____

Supplements: _____

Other: _____