

Accident Patient History

Name _____

Date _____

History of the Occurrence

Where did the accident happen: _____

Describe how the accident happened (example: I slipped and fell on the floor; a box fell on my head hurting my neck)

Symptoms From The Accident

Did you get bleeding cuts or bruises? Y or N

If Yes, what bleeding cuts did you get from this Accident? _____

If Yes, what bruises did you get from this Accident? _____

Please describe how you felt. PLEASE BE SPECIFIC

Immediately after the accident _____

Later that () day () night: _____

The next day: _____

Work Status History

Occupation or Job Title _____

Have you missed time from work? Y or N

If yes: Full Time off work _____ to _____.

Returned to Modified work _____ to _____.

() Been unable to work since the accident.

Complaints

Name _____

Date _____

A NECK OR CERVICAL SPINE	NONE	MILD	MODERATE	SEVERE
<i>A</i> Neck Pain and Soreness	A	B	C	D
<i>B</i> Loss or Pain upon Movement	A	B	C	D
<i>C</i> Shoulder Pain	A	B	C	D
<i>D</i> Pain/Numbness/Tingling into arm or hand	A	B	C	D
<i>E</i> Weakness in arm or hand	A	B	C	D
B MID-BACK OR THORACIC SPINE	NONE	MILD	MODERATE	SEVERE
<i>A</i> Mid-back Pain	A	B	C	D
<i>B</i> Rib or Chest Pain	A	B	C	D
C LOWER BACK OR LUMBAR SPINE	NONE	MILD	MODERATE	SEVERE
<i>A</i> Lower Back Pain or Soreness	A	B	C	D
<i>B</i> Loss or Pain with Movement	A	B	C	D
<i>C</i> Pain into Hips or Buttochs	A	B	C	D
<i>D</i> Pain into Legs, Knees, or Feet	A	B	C	D
<i>E</i> Numbness/Burning in Legs or Feet	A	B	C	D
D OTHER COMPLAINTS:	NONE	MILD	MODERATE	SEVERE
<i>A</i> Headaches	A	B	C	D
<i>B</i> Visual Disturbances/ Blurry Vision	A	B	C	D
<i>C</i> Ringing or Buzzing in Ears	A	B	C	D
<i>D</i> Nausea or Vomiting	A	B	C	D
<i>E</i> Difficulty Breathing	A	B	C	D
<i>F</i> Dizziness	A	B	C	D
<i>G</i> Recent Weight Loss	A	B	C	D
<i>H</i> Bowel or Bladder Dysfunction	A	B	C	D
E AGGRAVATED BY:	NONE	MILD	MODERATE	SEVERE
<i>A</i> Coughing	A	B	C	D
<i>B</i> Sneezing	A	B	C	D
<i>C</i> Prolonged Sitting	A	B	C	D
<i>D</i> Prolonged Standing	A	B	C	D
<i>E</i> Prolonged Riding in a Car	A	B	C	D
<i>F</i> Lying on Stomach	A	B	C	D

Activities of Daily Living

(Oswestry Back Disability Index)

Name _____

Date _____

Directions: Please circle the **one** choice in **each** section that **best** describes how your pain effects you **today**.

A: Pain Intensity

- a I have no pain
- b The pain doesn't interfere with activity
- c The pain is made worse with activity
- d I have to take something for the pain
- e I have to reduce my activity because of the pain
- f The pain prevents me from being active

B: Personal Care

- a I can wash or dress without pain or discomfort
- b Sometimes the way I wash or dress causes some pain
- c Washing or dressing increases my pain, but I manage
- d I have to change the way I wash or dress because of pain
- e I usually need some help to wash or dress myself
- f I cannot wash or dress myself without help

C: Lifting

- a I can lift heavy weights without pain
- b Lifting heavy weights causes pain
- c Pain prevents me from lifting heavy weights from the floor
- d I can manage heavy weights if they are conveniently placed
- e I can manage medium weights if they are conveniently placed
- f I can only lift very light weights, at the most

D: Walking

- a Pain does not prevent me from walking any distance
- b Pain prevents me from walking more than one mile
- c Pain prevents me from walking more than one half mile
- d Pain prevents me from walking more than one quarter mile
- e I can only walk using a cane or crutches
- f I am in bed most of the time and have to crawl to the toilet

E: Sitting

- a I can sit in a chair as long as I like
- b I can sit in my favorite chair as long as I like
- c Pain prevents me from sitting longer than one hour
- d Pain prevents me from sitting longer than thirty minutes
- e Pain prevents me from sitting longer than ten minutes
- f I cannot sit at all because of the pain

F: Standing

- a I can stand as long as I wish
- b I have some pain with standing
- c I cannot stand longer than one hour because of the pain
- d Pain prevents me from standing longer than thirty minutes
- e Pain prevents me from standing longer than ten minutes
- f I avoid standing because it causes immediate pain

G: Sex Life (optional)

- a Pain does not interfere with normal sexual relations
- b Sex causes some pain but not that bad
- c I have to reduce or change the way I have sex
- d I avoid sex because it increases my pain
- e Sex causes my pain to be very severe
- f I cannot have sexual relations because of my pain

H: Social Life

- a My social life is normal and not effected by pain
- b My social life is normal, but increases my degree of pain
- c Pain limits my energetic interests, like sports or dancing
- d Pain limits my social life and I don't get out often
- e Pain has restricted my social life to my home
- f I hardly have a social life because of the pain

I: Sleeping

- a I get no pain while lying in bed
- b I get pain while in bed, but it doesn't interfere with sleeping
- c Because of pain my normal night's sleep is reduced
- d I can only get one half a night's sleep because of the pain
- e I can only get a couple of hours sleep because of the pain
- f The pain prevents me from sleeping at all

J: Traveling

- a I get no pain while traveling
- b I get some pain while traveling, but it doesn't interfere
- c Traveling causes pain, but I can stand it
- d Pain restricts the kind of traveling I can do
- e Pain restricts all forms of travel
- f I can only travel lying down

