

INJURY REPORT

Patient Name _____

(PLEASE CHECK or CIRCLE ALL THAT APPLY)

▶ **Were you hit: from behind, head-on, side-swiped, or struck another vehicle?**

▶ **Describe what happened** (ie: front, side rear impacts) _____

▶ **Date of current AUTO accident?** _____

▶ **Any previous Auto accidents?** No Yes

If YES, when? _____ Did you receive treatment for that injury? No Yes

▶ **In the most recent Auto accident, were you the:**

Driver Passenger Pedestrian On bike

▶ **Please locate your position at the time of the accident:**

Front Seat Rear seat, passenger side Rear seat, driver side

▶ **Were you:**

Stopped and Struck From Behind Hit From Right Side
 Moving and Struck From Behind Hit From Left Side
 Stopped and Struck in Front-End Side Swiped
 Moving and Struck in Front-End Did more than one impact occur?

▶ **Were you wearing a seat belt?** Yes No

▶ **Upon impact, which way was your head turned?**

Left Right Ahead

▶ **Upon impact did any portion of your body strike any objects in the car?** Yes No

If YES, what portion of your body did you strike? (Please write L for left and R for right)

Head -- Knees -- Arms -- Hands -- Shoulders -- Other _____

▶ **What objects did you strike?**

Steering Wheel Dash Board
 Side Window Left Right Rear View Mirror
 Side Door Left Right Windshield
 Center Console Headrest
 Can't Remember _____
 Other _____

Check symptoms you have noticed since accident.

Head & Neck

- | | | | |
|-------------------------------|--------------------------|-----------------------------|--------------------------|
| Neck Pain | <input type="checkbox"/> | Dizziness | <input type="checkbox"/> |
| Neck Stiffness | <input type="checkbox"/> | Head Seems too Heavy | <input type="checkbox"/> |
| Neck Spasms | <input type="checkbox"/> | Grinding Sensations in Neck | <input type="checkbox"/> |
| Headaches | <input type="checkbox"/> | Loss of Balance | <input type="checkbox"/> |
| Arm Pain | <input type="checkbox"/> | Loss of Memory | <input type="checkbox"/> |
| Pins/Needles in Arms | <input type="checkbox"/> | Nervousness | <input type="checkbox"/> |
| Numbness in Fingers | <input type="checkbox"/> | Fatigue | <input type="checkbox"/> |
| Hands Cold | <input type="checkbox"/> | Sleeping Problems | <input type="checkbox"/> |
| Eyes Sensitive to Light | <input type="checkbox"/> | Fainting Spells | <input type="checkbox"/> |
| Any Other Pain or Sensations? | <input type="checkbox"/> | _____ | |

Rate your pain at its worst on a scale of 0-10 (0 = None; 10 = worst)

Mid-Back

- | | | | |
|-------------------------------|--------------------------|--|--------------------------|
| Mid Back Pain | <input type="checkbox"/> | Shortness of Breath | <input type="checkbox"/> |
| Mid Back Stiffness | <input type="checkbox"/> | Chest Pain | <input type="checkbox"/> |
| Mid Back Spasms | <input type="checkbox"/> | Breathing, Coughing, Sneezing
Results in Increase of Pain | <input type="checkbox"/> |
| Pain in Ribs/Side | <input type="checkbox"/> | | |
| Any Other Pain or Sensations? | <input type="checkbox"/> | _____ | |

Rate your pain at its worst on a scale of 0-10 (0 = None; 10 = worst)

Low Back

- | | | | |
|-------------------------------|--------------------------|--|--------------------------|
| Low Back Pain | <input type="checkbox"/> | Numbness in Toes | <input type="checkbox"/> |
| Low Back Stiffness | <input type="checkbox"/> | Feet Cold | <input type="checkbox"/> |
| Low Back Spasms | <input type="checkbox"/> | Breathing, Coughing, Sneezing
Results in Increase of Pain | <input type="checkbox"/> |
| Leg/Hip Pain | <input type="checkbox"/> | | |
| Pins/Needles in Legs | <input type="checkbox"/> | | |
| Any Other Pain or Sensations? | <input type="checkbox"/> | _____ | |

Rate your pain at its worst on a scale of 0-10 (0 = None; 10 = worst)

► **Were you?**

- Dazed Unconscious Cut (Where?) _____
- Bruised, where? _____
- Cuts/scrapes, where? _____
- Other Injuries not Listed Above? _____

► **Did you have:**

- Momentary Deafness Loss of Balance Nausea
- Ringing in Ears Blurred Vision Dizziness
- Immediate Pain Gradual Pain

► **Were the symptoms present before the accident?**

- Yes No

► **If Yes, please describe** _____

► **What Hospital?**

WakeMed Rex Duke Health Raleigh Other _____

► **If you were taken to the Emergency Room immediately, How?**

Ambulance Drove Yourself Taken by Someone Other _____

► **If you went home and later went to the Emergency Room or other Doctor?**

Date Hospital Doctor _____

► **Were you seen in the Emergency Room?**

- Yes No

► **Were you admitted to the Hospital?**

- Yes No

► **What procedure were done in the Emergency Room/Hospital?**

Examination Stitches X-Rays Neck Collar Brace Shot

Pain Pills Muscle Relaxers Anti-Inflammatory Other _____

► **Are you taking any other medications currently, if yes, please list?**

Yes No _____

► **Have you seen any other Physicians for this problem, if yes, please name?**

Yes No _____

► **Are you pregnant?**

Yes No

► **Patient's Signature:** _____ ► **Date:** _____

► **Doctor's Notes** _____
