Initial Report of Injury

Name: ___________________________ Today's Date: ___________________

Date of Injury _________________ I **have/have not** seen another doctor since the injury. If so please list when and where: ____
I **did/did not** lose consciousness when the injury occurred. If so, for how long? _______
I **was/was not** hospitalized after this incident. If so, please list when and where _______
____

For all questions, please use reverse side if more space is needed.

1. Description of incident: ____
____

2. Please note any areas of pain or impairment previous to above incident: _________
____

3. Please note areas of pain or impairment since injury: __________________________
____

Mark with an "X" to describe your current experience with the following activities:

ACIVITY	NORMAL	LIMITED	DIFFICULT	PAINFUL
Walking				
Standing				
Sitting				
Bending				
Lifting				
Reaching				
Pushing/Pulling				
Using Stairs				
Getting up from a chair				
Gripping				
Desk Work				
Sleeping				

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