THE CONCUSSION PLACE

Accident or Injury Form

TODAY'S DATE:

PATIENT INFORMATION			
Last Name:	**First Name:**	**MI:**	**Birth Date:**

NECK, MIDDLE BACK & UPPER EXTREMITY QUESTIONNAIRE		
YES	**NO**	**NECK REGION**
☐	☐	Does neck and head movement cause your neck pain to intensify?
☐	☐	Do you get dizzy when you look up or twist your head? If yes, how often:
☐	☐	Do you black out or lose your balance when you look up or twist your head? If yes, how often:
☐	☐	Do you have to support your head with your hand or grasp your mouth or hair to be able to lift your head up when you are lying down and attempting to sit up?
☐	☐	Does your neck pain send pain downwards between your shoulders?
☐	☐	Dies your neck pain send pain downwards to the front of your chest?
☐	☐	Have you noticed your head leaning or tilting to one side recently?
☐	☐	Have you ever been diagnosed with a disc bulge or disc herniation in your neck?
☐	☐	Does your neck make a “clunk” or other unusual sound when you move it?
☐	☐	Any other concerns with this area of your body?:
YES	**NO**	**SHOULDER, ARM, HAND & FINGER REGION**
☐	☐	Do you have pain in your shoulder(s)? If yes, describe where:
☐	☐	Does arm motion make your shoulder pain worse? Describe:
☐	☐	Do you have pain, numbness, or tingling in your upper arm, elbow, forearm, or hand? Circle areas.
☐	☐	Do you have pain, numbness, or tingling in your fingers? If Yes, circle finger(s) that are involved: Thumb, Index finger, Middle finger, Ring finger, Little finger
☐	☐	Do your symptoms worsen when lying flat on your back or sleeping on your side?
☐	☐	Do your symptoms worsen in a seated position?
☐	☐	If you sit and slouch forward for several minutes, do your arm symptoms intensify?
☐	☐	If you have arm/hand symptoms, do they improve when you lift your arms over your head?
☐	☐	If you have arm/hand symptoms, do they worsen when you lift your arms over your head?
☐	☐	If you have hand or arm pain at night, does it help to shake and massage them?
☐	☐	Do your hands feel tender when you grasp objects?
☐	☐	Do you feel weakness in your grip strength or do you drop objects from your hand?
☐	☐	Do you have difficulty writing or doing small motions with your fingers recently?
☐	☐	Do your hands or wrists swell?
☐	☐	Do your fingers or hands burn or become cold?
☐	☐	Have you been diagnosed as having Carpal Tunnel Syndrome or Raynaud's syndrome?
☐	☐	Any other concerns with this area of your body?:
YES	**NO**	**MIDDLE BACK & CHEST WALL REGION**
☐	☐	Do you have pain that shoots or radiates outward along your rib cage?
☐	☐	Does your middle back or chest wall pain intensify when you take in a deep breath or cough?
☐	☐	Does your middle back or chest wall pain intensify when you twist your torso, bend, or stoop forward?
☐	☐	Does your middle back pain or chest pain intensify when you move your head or neck?
☐	☐	Have you been diagnosed as having angina before?
☐	☐	Do you have a tight band-like feeling around your chest?
☐	☐	Do you have any unusual indigestion, chest pressure, or pain down your left arm?
☐	☐	Is your middle back pain worse when you sleep?
☐	☐	Any other concerns with this area of your body?:

CHECK ANY OF THE FOLLOWING THAT INTENSIFY OR WORSEN YOUR NECK OR ARM SYMPTOMS			
☐ Sitting	☐ Walking	☐ Lifting	☐ Keying / Typing
☐ Standing	☐ Bending forward	☐ Reaching	☐ Other:
☐ Other body/limb or head/neck positions:			

CHECK ANY OF THE FOLLOWING THAT LESSEN OR IMPROVE YOUR NECK OR ARM SYMPTOMS			
☐ Sitting	☐ Walking	☐ Lying on your stomach	☐ Bending backward
☐ Standing	☐ Bending forward	☐ Lying on your back	☐ Other:
☐ Other body/limb or head/neck positions:			

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LOW BACK, PELVIS & LOWER EXTREMITY QUESTIONNAIRE		
YES	**NO**	
☐	☐	When you cough, sneeze, or bear down to have a bowel movement, does your back/leg pain get intensify?
☐	☐	Do you have a consistent pattern of getting severe leg pain or cramping after walking for similar distances that is relieved by resting or sitting down? This pain resumes after walking for same distance.
☐	☐	Do you get leg pain or hip pain while walking that is consistently relieved by sitting down or lying down? This pain doesn't bother you at night or while sitting.
☐	☐	Does either leg or foot drag on the floor when you walk?
☐	☐	Are you experiencing leg cramps, particularly at night?
☐	☐	Have you recently had any urinary or bowel incontinence or had difficulty urinating?
☐	☐	Have you had abdominal pain, indigestion, colicky symptoms with your low back pain?
☐	☐	Have you noticed low back pain during basic movements/stretching?
☐	☐	Do your feet feel cold recently? If yes, indicate which foot or if both feet:
☐	☐	Have you ever been diagnosed as having a herniated or bulging disc in your low back in the past?
☐	☐	Have you ever had an injection of Chymopapain into your discs (Spine) in your back or neck?
☐	☐	Have you recently noticed that either of your legs occasionally gives out on you when you walk?
☐	☐	Does one or both of your legs feel weak recently?
☐	☐	Have you ever been diagnosed as having a spondylolisthesis in your low back region?
☐	☐	Have you or either of your parents ever been diagnosed as having an abdominal aneurysm?
☐	☐	If you have radiating leg or foot pain did you notice your leg symptoms before the low back pain started?
☐	☐	If you have leg pain, is your pain primarily focused in front of your thigh(s)?
☐	☐	Has your anal-rectal region been completely numb?
☐	☐	Do you have any recent prostate, ovarian, or uterine problems?
☐	☐	Have you ever had abdominal surgery, chest surgery, reconstructive surgery?
☐	☐	Any other issues that you weren't asked about here?:

CHECK ANY OF THE FOLLOWING THAT INTENSIFY OR WORSEN YOUR LOW BACK OR LEG SYMPTOMS			
☐ Sitting	☐ Walking	☐ Lying on your stomach	☐ Bending backward
☐ Standing	☐ Bending forward	☐ Lying on your back	☐ Other:
☐ Other body/limb positions:			

CHECK ANY OF THE FOLLOWING THAT LESSEN OR IMPROVE YOUR LOW BACK OR LEG SYMPTOMS			
☐ Sitting	☐ Walking	☐ Lying on your stomach	☐ Bending backward
☐ Standing	☐ Bending forward	☐ Lying on your back	☐ Other:
☐ Other body/limb positions:			

DISABILITY			
WORK DISABILITY			
Have you missed work due to this concussion?	☐ No ☐ Yes		
If yes, were your disabled partially or fully?	☐ Partial ☐ Full Disability		
If yes, dates: from to & from to & from to			
SCHOOL DISABILITY			
Have you missed school due to this concussion?		☐ No ☐ Yes	
If yes, were your disabled partially or fully?		☐ Partial ☐ Full Disability	
If yes, dates: from to & from to & from to			

OFFER ANY INORMATION TO HELP US UNDERSTAND YOUR LIMITATIONS

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POST-TRAUMATIC SYMPTOM QUESTIONNAIRE				
SYMPTOM LIST Check all of the symptoms that began or worsened after your injury that apply to you.	Began less than 24 hours after the injury	Began 1 to 7 days after the injury	Check here if this symptom is still present	Check here if you were you treated for a similar symptoms within 6 months of the injury
Headache/migraine				
Nausea and/or vomiting				
Tinnitus (ear ringing)				
Blurry vision				
Memory problems				
Poor concentration				
Dizziness or giddiness				
Feel unsteady when dark at night-time				
Balance problems standing or moving about				
Loss of coordination with arms/hands/legs				
Feel unsteady on feet walking or getting-up				
Misjudges distance when moving about				
Feel unsteady bending down to pick-up items				
Tripping while walking				
Light-headed when turning head-looking up				
Lack of smooth arm/hand motion				
Sensitivity to light or sound				
Fatigue				
Loss of smell				
Personality changes				
Word-finding challenges				
Irritability				
Forgetfulness				
Anger/rage				
Pain/difficulty swallowing				
Jaw pain/soreness				
Neck pain/soreness/aching/stiff				
Shoulder pain/stiffness				
Arm/hand pain/tingling/numbness				
Weakness in arms/legs				
Upper/middle back pain/soreness				
Chest pain or bruising				
Rib cage pain or bruising				
Abdominal-Pelvic pain or bruising				
Low back pain/soreness/aching				
Hip pain or bruising				
Upper leg or thigh pain				
Leg numbness/tingling				
Pain radiating down leg(s)				
Lower leg or calf pain				
Knee pain				
Ankle/foot/toe pain				
Other:				
Other:				
Other:				
Other:				

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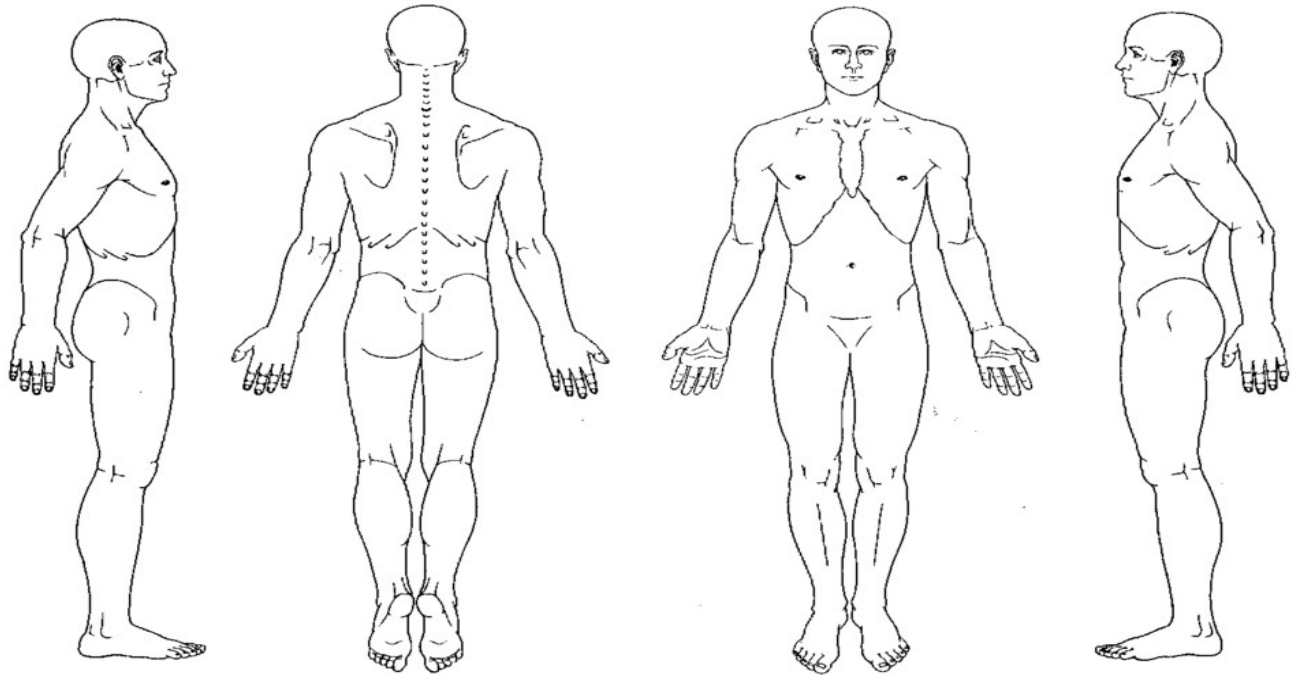
PAIN DIAGRAM

Mark the diagram to best illustrate any areas of **SHARP OR STABBING PAIN** by shading in the affected areas.



Please feel free to write in your own notes to help us understand your symptoms.

PAIN SCALE

(Mark the appropriate level of discomfort or dysfunction caused by this symptom)

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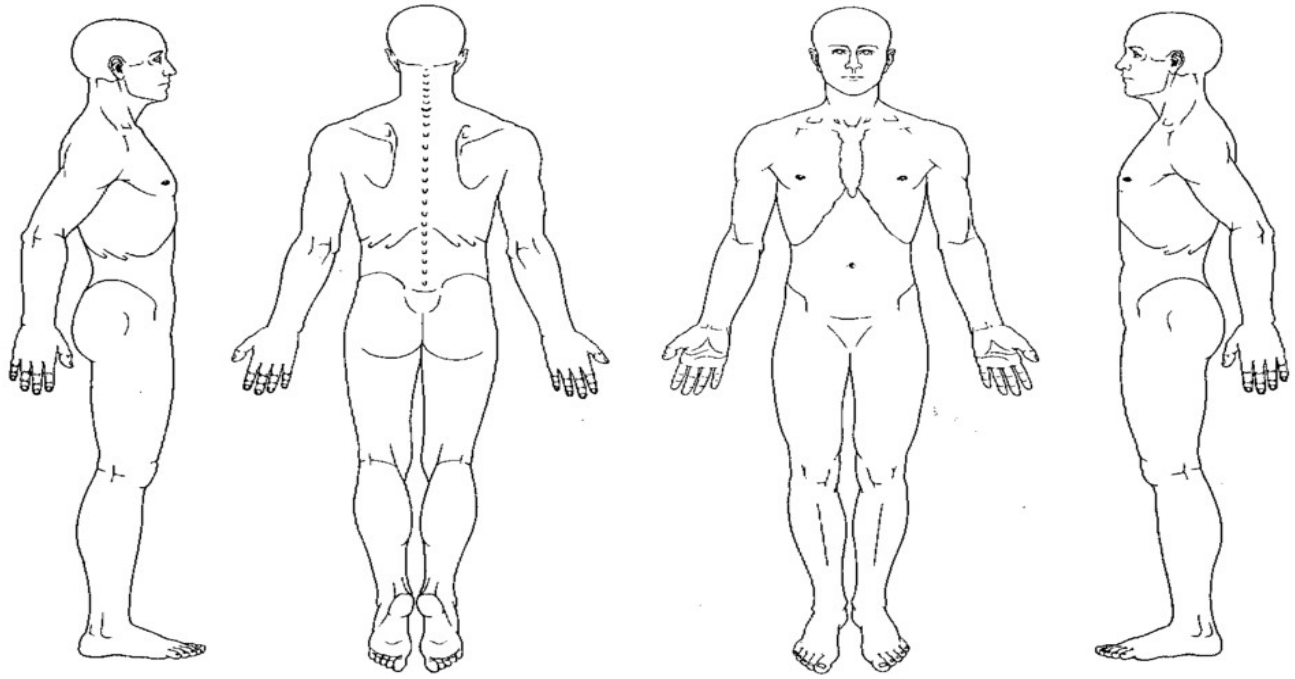
PAIN DIAGRAM

Mark the diagram to best illustrate any areas of **DULL OR ACHING PAIN** by shading in the affected areas.



Please feel free to write in your own notes to help us understand your symptoms.

PAIN SCALE

(Mark the appropriate level of discomfort or dysfunction caused by this symptom)

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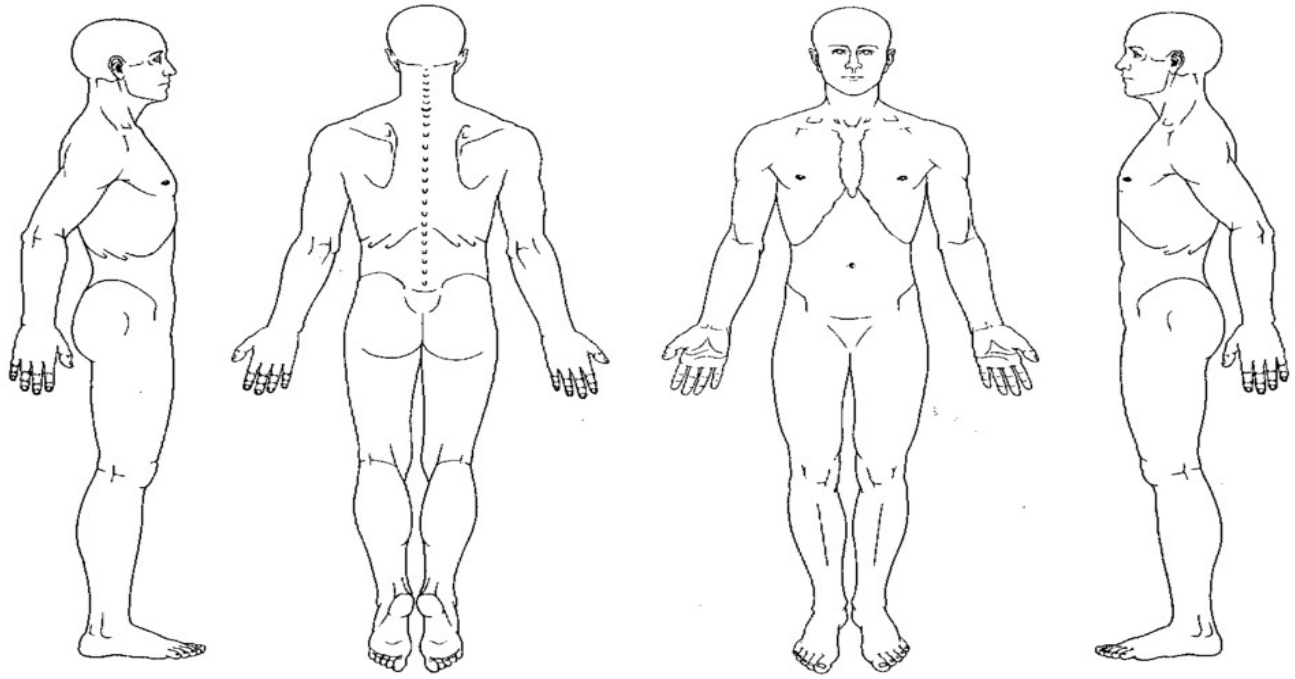
PAIN DIAGRAM

Mark the diagram to best illustrate any areas of **NUMBNESS, TINGLING, OR BURNING** by shading in the affected areas.



Please feel free to write in your own notes to help us understand your symptoms.

PAIN SCALE

(Mark the appropriate level of discomfort or dysfunction caused by this symptom)

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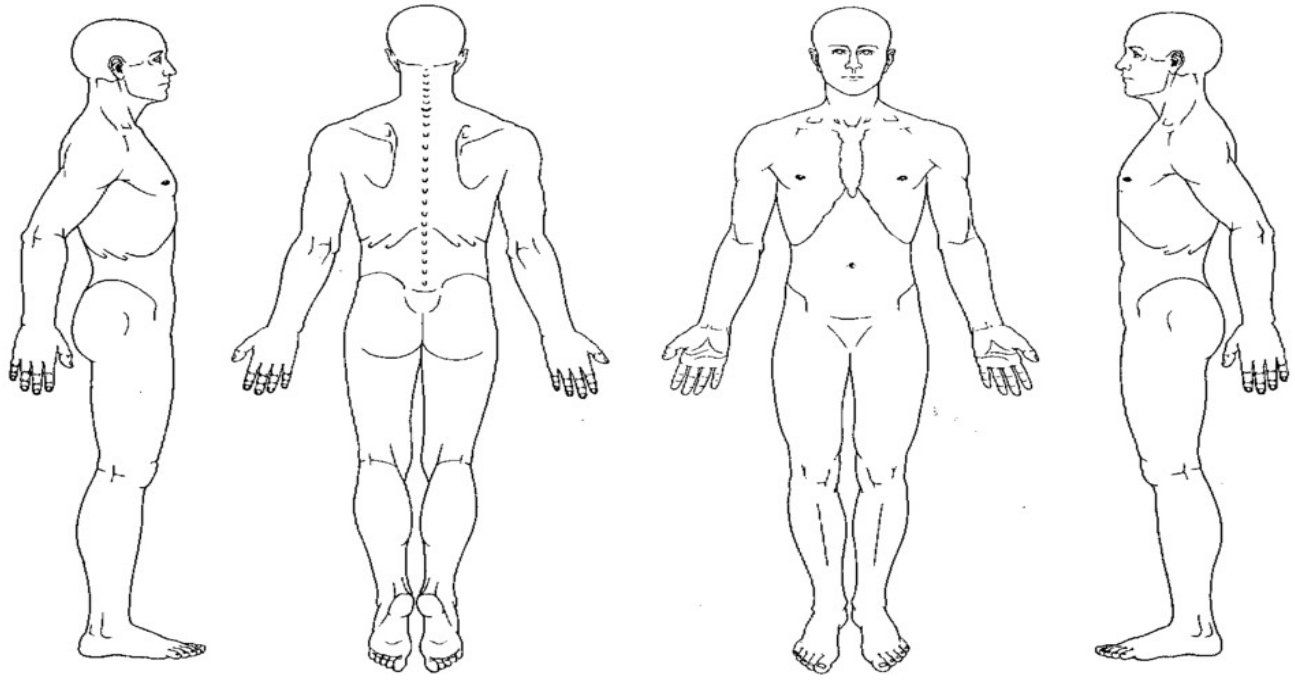
PAIN DIAGRAM

Mark the diagram to best illustrate any areas of **BRUISING, CUTS, SCRAPES OR FRACTURES** by shading in the affected areas.



Please feel free to write in your own notes to help us understand your symptoms.

PAIN SCALE

(Mark the appropriate level of discomfort or dysfunction caused by this symptom)

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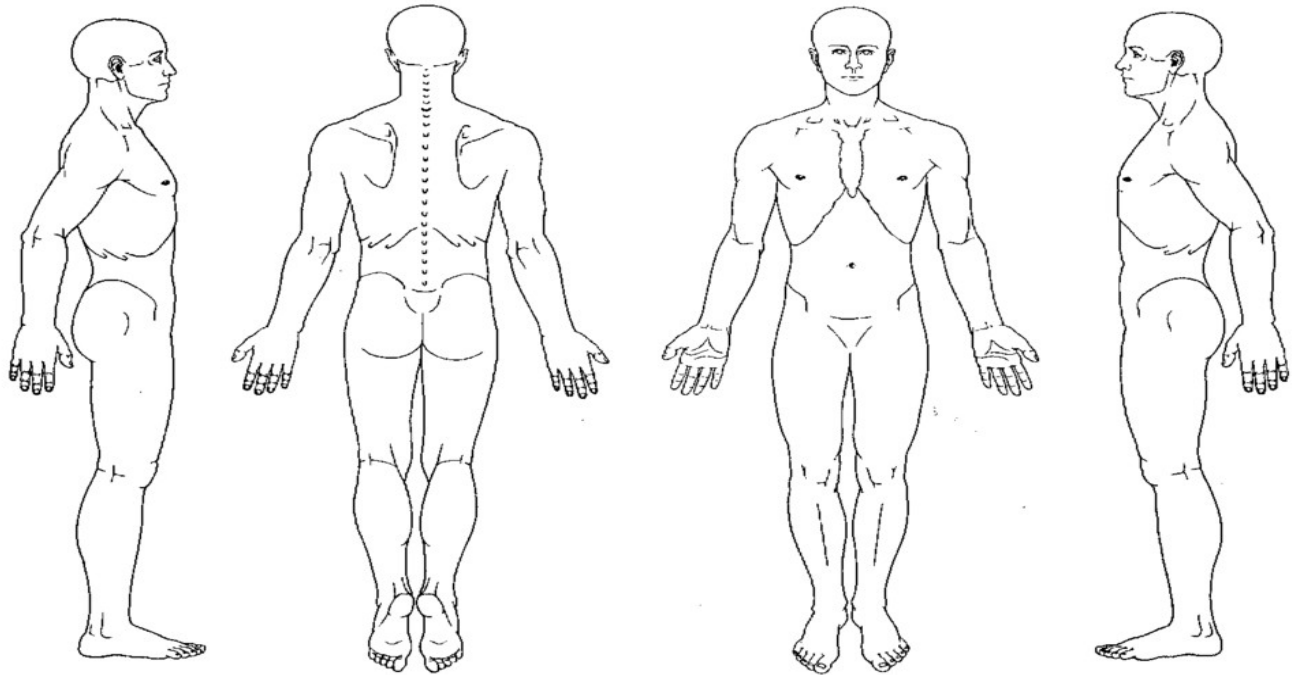
PAIN DIAGRAM

Mark the diagram to best illustrate any areas of **OTHER PAIN OR DISCOMFORT** by shading in the affected areas.

List the complaint here: _____



Please feel free to write in your own notes to help us understand your symptoms.

PAIN SCALE

(Mark the appropriate level of discomfort or dysfunction caused by this symptom)

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MOTOR VEHICLE CRASH FORM

(Only complete this section if you were involved in an automobile crash)

YES	NO	DETAILS OF THE INCIDENT
☐	☐	Did the police come to the scene?
☐	☐	Did the police make a copy of the report? If yes, please provide the report for us.
☐	☐	Was fault determined in the incident? If so, who was at fault?:
☐	☐	Were photos taken of the vehicles or scene? If so, who took them?

Date of crash: Approximate Time: ☐ AM ☐ PM

City/State: Street: Was the street ☐ Dry , ☐ Wet, or ☐ Icy?

Who owns the vehicle you were in?

What was the estimated damage to the vehicle? $ ☐ Unknown ☐ Estimate not done yet

How many people were in the vehicle at the time of the crash?

COLLISION DESCRIPTION-TYPE (*Check all that apply*)

☐ I was hit from the rear	☐ Head-on or frontal crash	☐ My vehicle rolled or flipped
☐ I hit someone from the rear	☐ Three-or-more vehicles involved	☐ I hit someone while going in reverse
☐ I was hit from the side	☐ Single-vehicle crash	☐ Ran off the road
☐ I hit someone in the side	☐ Hit guard rail, tree, or object	☐ Other :

CIRCLE YOUR SEATING POSITION

The number's 1-9 indicate where you were seated at the time of the crash.
The #1 spot is the driver. Seating numbers 7-9 are for a third row seat.

Front of Vehicle

1	2	3
4	5	6
7	8	9

Driver's Side — Passenger Side

Rear of Vehicle

WHAT TYPE OF VEHICLE WERE YOU IN?

Year: Make: Model: ☐ Unknown

WHAT WAS THE OTHER TYPE OF VEHICLE?

Year: Make: Model: ☐ Unknown

AT THE TIME OF THE CRASH, YOUR VEHICLE WAS...

☐ Stopped	☐ Moving at a steady speed	☐ Unknown
☐ Slowing down	☐ Gaining speed	☐ Other

AT THE TIME OF THE CRASH, THE OTHER VEHICLE WAS...

☐ Stopped	☐ Moving at a steady speed	☐ Unknown
☐ Slowing down	☐ Gaining speed	☐ Other

DURING AND AFTER THE CRASH, YOUR VEHICLE...

☐ Stopped without striking anything else	☐ Spun around without striking anything	☐ Was struck by another vehicle
☐ Continued straight, striking a vehicle	☐ Spun around, striking another vehicle	☐ My vehicle rolled
☐ Continued straight, striking an object	☐ Spun around, striking an object	☐ I was ejected from the vehicle

WERE ANY OF THESE PARTS OF THE INTERIOR OF THE VEHICLE DAMAGED?

☐ Windshield	☐ Side or rear window broken	☐ Seat or headrest
☐ Steering wheel	☐ Any part of the dashboard or console	☐ Internal door or knobs
☐ Seat belt	☐ Sun visor	☐ Other:
☐ Door wouldn't open	☐ Airbags deployed (front / side / headrest)	☐ Other:

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DID ANY PARTS OF YOUR BODY STRIKE THE INSIDE OF THE VEHICLE?	
BODY PART	**LIST PART OF VEHICLE OR OBJECT THAT WAS CONTACTED**
☐ Head	
☐ Face	
☐ Shoulder	
☐ Arm/hand	
☐ Front of chest	
☐ Side of chest	
☐ Abdomen	
☐ Back	
☐ Hip	
☐ Knee	
☐ Leg	
☐ Foot	
☐ Other:	

BODY POSITION AT THE MOMENT OF IMPACT			
HEAD POSITION	**HAND POSITION**	**TRUNK POSITION**	**FOOT POSITION**
☐ Facing forward	☐ On wheel: left right both	☐ Neutral in seat	☐ On brake: left right both
☐ Turned left	☐ On shifter: left right both	☐ Rotated left	☐ On accelerator: left right both
☐ Turned right	☐ On lap: left right both	☐ Rotated right	☐ On clutch: left right both
☐ Angled downward	☐ Reaching: left right both	☐ Bending forward	☐ On floorboard: left right both
☐ Angled upward	☐ Holding object: left right both	☐ Bending backward	☐ On seat: left right both
☐ Other:	☐ Other:	☐ Other:	☐ Other:

HEAD REST		
☐	☐	Were you restrained?
☐	☐	If so, did you have bruises or cuts from your seat belt?
☐	☐	Did your airbags deploy? If so, check all that apply: ☐ front ☐ side ☐ active headrest
☐	☐	Were you expecting or bracing for the impact?

COLLISION DESCRIPTION-TYPE (*Check all that apply*)		
☐ I was hit from the rear	☐ Head-on or frontal crash	☐ My vehicle rolled or flipped
☐ I hit someone from the rear	☐ Three-or-more vehicles involved	☐ I hit someone while going in reverse
☐ I was hit from the side	☐ Single-vehicle crash	☐ Ran off the road
☐ I hit someone in the side	☐ Hit guard rail, tree, or object	☐ I was ejected from the vehicle
☐ Other :		