

Symptoms

Patient _____ Date _____ Date of Injury _____

Please fill in all symptoms you currently have that you did not have before the accident.

Orthopedic & Musculoskeletal Symptoms

- "Clunk" sound with neck movements
- Neck pain
- Upper back pain
- Low back pain
- Shoulder pain Left Right
- Upper arm pain Left Right
- Elbow pain Left Right
- Forearm pain Left Right
- Wrist pain Left Right
- Hand pain Left Right
- Hip pain Left Right
- Upper leg pain Left Right
- Knee pain Left Right
- Lower leg pain Left Right
- Ankle pain Left Right
- Foot pain Left Right
- Jaw pain
- Clicking in Jaw
- Pain when chewing
- Face pain
- Chest pain
- Stomach pain
- Bruise to _____
- Scrape/Cut to _____
- Other Symptom _____
- Other Symptom _____

Neurological Symptoms

- Numb/Tingling Arm / Hand L R
- Numb/Tingling Leg / Foot L R
- Weakness Arm / Hand L R
- Weakness Leg / Foot L R

Symptoms Associated with Injuries

- Stiffness or limited movement in joint(s)
- Headaches
- Muscle spasms/sore muscles
- Dizziness, lightheaded, woozy feeling
- Visual disturbances or vision change
- Sleep changes/disruption of patterns
- Pain radiates from one place to another
- Anxiety or nervous when driving
- Feeling depressed about things
- I am taking medications _____

Brain/Neuropsych/MTBI Symptoms

- I prefer being alone now (not socializing)
- Sleepy, tired during day or dozing off
- Upset stomach, nausea, heartburn or vomiting
- Difficulty concentrating, mind wanders easily
- Get overwhelmed easily
- Mood swings, happy one moment then sad
- Agitation (can't sit still, need to move around)
- Sadness, tearful episodes, crying easily
- Blurry vision, had to get or change glasses
- Asking people to repeat things often
- Get lost easily or can't remember time
- Get confused easily
- Difficulty finding words when talking
- Bright lights bother me
- Cannot pay attention as long as before
- Eating more or less than normal
- Pupils different sizes
- Room spins, lightheaded or woozy feeling
- Bumping into furniture, doors or walls
- Balance problems
- Difficulty focusing as long as I used to
- I feel like my head is "Foggy"
- I have forgotten computer passwords
- Personality change
- I have forgotten my ATM PIN number
- I have to re-read things to understand what I read
- My thinking is slowed down
- Difficulty with adding/subtracting numbers
- Fear I will never be the same again
- Difficulty learning new things
- Difficulty understanding what people say to me
- Difficulty remembering or memory problems
- Cannot take on any more responsibility
- Get angry easily, road rage, yelling at people
- I can't make decisions as quickly as before
- Loss of libido or lack of sexual desire
- I do not feel as confident of my abilities
- I get panic attacks, fast heartbeat, nervous
- I don't care about important things
- I am more irritable than usual
- Some food or drink tastes "Funny" to me now
- Flashbacks to accident or nightmares about it
- Less patient with spouse, family, or others
- I get frustrated very easily
- Loud noises annoy me (or other hearing problem)
- Difficulty planning my life or organizing my work

Diagnosis for _____ Date of Injury: _____

Diagnosis Status: Initial Update Date of Diagnosis: _____

Cervical Spine Injuries

- 847.0 Cervical Sp/St
- 839.00 Cervical Sublux. Unspecified
- 839.08 Multiple Cervical Sublux.
- 728.4 Cerv. Ligt. Laxity
- 728.5 Cerv. Hypermobility
- 720.1 Cerv. Enthesopathy
- 723.1 Cervicalgia
- 728.85 Cerv. Myospasm
- 729.1 Cervical Myalgia
- 737.29 Loss of Cerv. Lordosis
- 737.19 Traumatic Cerv. Kyphosis
- 738.2 Acquired Cerv. Deformity
- 722.0 Cerv. Disk Herniation/Neuritis
- 953.0 Cerv. Nerve Injury
- 723.3 Cervicobrachial Nerve Injury
- 782.0 Cerv. Sensation Disturbance
- 728.2 Upper Extremity Atrophy
- 728.9 Upper Extremity Weakness
- 722.4 Cervical DJD/DDD
- 722.81 Post Cervical Laminectomy

Thoracic Spine Injuries

- 847.1 Thoracic Sp/St
- 839.21 Thoracic Subluxation
- 728.4 Thor. Ligt. Laxity
- 728.5 Thor. Hypermobility
- 720.1 Thor. Enthesopathy
- 724.1 Thoracalgia
- 728.85 Thoracic Myospasm
- 729.1 Thoracic Myalgia
- 848.3 Ribs Sprain/Strain
- 839.8 Rib Cage Subluxation
- 848.41 Sternoclavicular Sp/St
- 786.50 Chest Pain
- 722.11 Thor. Disc Herniation
- 853.1 Thor. Nerve Injury
- 724.4 Thoracic Neuritis
- 953.4 Brachial Plex. Nerve Inj.
- 353.0 Brachial Plexus Lesion
- 722.51 Thoracic DJD/DDD

Lumbar Spine Injuries

- 847.2 Lumbar Sp/St
- 839.20 Lumbar Subluxation
- 728.4 Lumb.Ligt.Laxity
- 728.5 Lumb.Hypermobility
- 720.1 Lumb. Enthesopathy
- 724.2 Lumbago
- 728.85 Lumb. Myospasm
- 729.1 Lumbar Myalgia
- 722.10 Lumbar Disk Herniation
- 953.2 Lumbar Nerve Injury
- 724.4 Lumbar Neuritis
- 782.0 Sensation Disturbance
- 728.2 Leg Atrophy
- 728.9 Leg Muscle Weakness
- 729.5 Leg Limb Pain
- 729.81 Leg Swelling
- 722.52 Lumb DJD/DDD
- 722.83 Post Laminectomy
- 756.12 Spondylolisthesis
- 719.7 Difficulty Walking

Upper Extremity Injuries

- 839.8 Upper Extremity Subluxation
- 728.85 Upper Extremity Myospasm
- 729.81 Upper Extremity Swelling
- 729.5 Upper Extremity Tissue Pain
- 840.9 Shoulder Sprain/Strain
- 719.40 UE Joint Pain - 1 Joint
- 719.49 UE Joint Pain - Mult. Joints
- 726.10 Shoulder Enthesopathy
- 841.9 Elbow Sprain/Strain
- 839.8 Elbow Subluxation
- 726.3 Elbow Enthesopathy
- 842.00 Wrist Sprain/Strain
- 839.8 Wrist Subluxation
- 726.4 Wrist Enthesopathy
- 842.10 Hand Sprain/Strain
- 839.8 Hand Subluxation

Lower Extremity Injuries

- 839.8 Lower Extremity Subluxation
- 728.85 Lower Extremity Myospasm
- 719.40 LE Joint Pain - 1 Joint
- 719.49 LE Joint Pain - Mult. Joints
- 729.81 Lower Extremity Swelling
- 729.5 Lower Extremity Tissue Pain
- 843.9 Hip/Thigh Sprain/Strain
- 726.5 Hip Region Enthesopathy
- 844.9 Knee Sprain/Strain
- 726.6 Knee Enthesopathy
- 845.00 Ankle Sprain/Strain
- 726.7 Ankle/Foot Enthesopathy
- 845.10 Foot Sprain/Strain
- 719.7 Difficulty Walking

Pelvis/Hip/Sacrum

- 846.9 Sacroiliac Sp/St
- 839.42 Sacroiliac Sublux.
- 847.3 Sacrum Sp/St
- 724.6 Sacrum Instability
- 847.4 Coccyx Sp/St
- 839.69 Hip/Pelvis Sublux.
- 724.3 Sciatic Neuritis
- 956.0 Sciatic NI
- 953.3 Sacral NI

Brain Injuries

- 850.0 Concussion/No LOC
- 850.1 Concussion/Brief LOC
- 850.2 Concussion Mod. LOC
- 854.00 Traumatic Brain Injury
- 907.0 Late FX of Brain Injury
- 784.0 Headache
- 780.5 Sleep Disturbance
- 780.54 Hypersomnolence
- 780.7 Fatigue/Lethargy/Tired
- 787.0 Nausea/Vomiting
- 780.4 Dizzy/Lightheaded
- 386.11 Positional Vertigo
- Other _____

MISC

- 308.0 Anxiety
- 300.4 Depression
- 309.81 Post Traumatic Stress Disorder
- 848.1 TMJ Sp/St
- 524.60 TMJ Pain
- 728.85 TMJ Myospasm
- 388.31 Tinnitus
- 401.1 Hypertension
- 250.0 Aggravation of Diabetes
- 781.9 Abnormal Posture 2ary to Trauma
- 788.30 Urinary Incontinence
- Other(s) _____
- Disability to _____
- Total Partial Limitations _____
- _____

Abrasions

- 910.0 Face, Neck, Head
- 911.0 Abdomen, Torso
- 912.0 Shoulder & Arm
- 913.0 Elbow, Arm, Wrist
- 914.0 Hand & Fingers
- 916.0 Hip/Thigh/Leg/Ankle
- 917.0 Foot & Toes

Contusions

- 920.0 Face, Neck, Head
- 922 Abdomen, Torso
- 923.0 Shoulder & Arm
- 923.1 Elbow, Arm, Wrist
- 923.2 Hand & Fingers
- 924.0 Hip/Thigh/Leg/Ankle
- 924.2 Foot & Toes

TREATMENT PLAN

Patient _____ Today's Date _____ DOI _____

The following recommended treatments are to be done through _____

<p>Cervical Spine Tx</p> <input type="checkbox"/> 98940(1)(2) Chiropractic Manip. <input type="checkbox"/> 97124 Massage _____ minutes <input type="checkbox"/> 97035 Ultrasound _____ minutes <input type="checkbox"/> 97014 Elect.Stim (unattended) <input type="checkbox"/> 97032 Elect.Stim (attended) <input type="checkbox"/> 97140 Myofascial Release <input type="checkbox"/> 97110 Ther.Exer. 1on1 _____ min <input type="checkbox"/> 97150 Ther.Exer.Group _____ min <input type="checkbox"/> Office Other _____ <input type="checkbox"/> Home Neck Exercises <input type="checkbox"/> Home Cervical Stabilization Collar <input type="checkbox"/> Home Ice Pack <input type="checkbox"/> Home Cervical Traction Pillow <input type="checkbox"/> Bed Rest <input type="checkbox"/> Home Other _____ <input type="checkbox"/> Gym Neck Exercises/Activity <input type="checkbox"/> MD <input type="checkbox"/> Exam <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> DMX	<p>Thoracic Spine Tx</p> <input type="checkbox"/> 98940(1)(2) Chiropractic Manip. <input type="checkbox"/> 97124 Massage _____ minutes <input type="checkbox"/> 97035 Ultrasound _____ minutes <input type="checkbox"/> 97014 Elect.Stim (unattended) <input type="checkbox"/> 97032 Elect.Stim (attended) <input type="checkbox"/> 97140 Myofascial Release <input type="checkbox"/> 97110 Ther.Exer. 1on1 _____ min <input type="checkbox"/> 97150 Ther.Exer.Group _____ min <input type="checkbox"/> Office Other _____ <input type="checkbox"/> Office Other _____ <input type="checkbox"/> Home Thoracic Traction Pillow <input type="checkbox"/> Home Upper Back Exercises <input type="checkbox"/> Home Ice Pack <input type="checkbox"/> Bed Rest <input type="checkbox"/> Home Other _____ <input type="checkbox"/> Gym Thoracic Exercises/Activity <input type="checkbox"/> MD <input type="checkbox"/> Exam <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> DMX	<p>Lumbar Spine Tx</p> <input type="checkbox"/> 98940(1)(2) Chiropractic Manip. <input type="checkbox"/> 97124 Massage _____ minutes <input type="checkbox"/> 97035 Ultrasound _____ minutes <input type="checkbox"/> 97014 Elect.Stim (unattended) <input type="checkbox"/> 97032 Elect.Stim (attended) <input type="checkbox"/> 97140 Myofascial Release <input type="checkbox"/> 97110 Ther.Exer. 1on1 _____ min <input type="checkbox"/> 97150 Ther.Exer.Group _____ min <input type="checkbox"/> Office Other _____ <input type="checkbox"/> Home Low Back Exercises <input type="checkbox"/> Home Ice Pack <input type="checkbox"/> Home Lumbar Stabilization Belt <input type="checkbox"/> Home Lumbar Traction Pillow <input type="checkbox"/> Bed Rest <input type="checkbox"/> Home Other _____ <input type="checkbox"/> Gym Lumbar Exercises/Activity <input type="checkbox"/> MD <input type="checkbox"/> Exam <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> DMX
<p>Upper Extremity Tx</p> <input type="checkbox"/> 98943 Chiropractic Manip. <input type="checkbox"/> 97124 Massage _____ minutes <input type="checkbox"/> 97035 Ultrasound _____ minutes <input type="checkbox"/> 97014 Elect.Stim (unattended) <input type="checkbox"/> 97032 Elect.Stim (attended) <input type="checkbox"/> 97140 Myofascial Release <input type="checkbox"/> 97110 Ther.Exer. 1on1 _____ min <input type="checkbox"/> 97150 Ther.Exer.Group _____ min <input type="checkbox"/> Office Other _____ <input type="checkbox"/> Office Other _____ <input type="checkbox"/> Home Upper Extremity Exercises <input type="checkbox"/> Home Ice Pack <input type="checkbox"/> Bed Rest <input type="checkbox"/> Gym Upper Extremity Exercises <input type="checkbox"/> MD <input type="checkbox"/> Exam <input type="checkbox"/> MRI <input type="checkbox"/> CT	<p>Lower Extremity Tx</p> <input type="checkbox"/> 98943 Chiropractic Manip. <input type="checkbox"/> 97124 Massage _____ minutes <input type="checkbox"/> 97035 Ultrasound _____ minutes <input type="checkbox"/> 97014 Elect.Stim (unattended) <input type="checkbox"/> 97032 Elect.Stim (attended) <input type="checkbox"/> 97140 Myofascial Release <input type="checkbox"/> 97110 Ther.Exer. 1on1 _____ min <input type="checkbox"/> 97150 Ther.Exer.Group _____ min <input type="checkbox"/> 97116 Gait Training/Stair Climb <input type="checkbox"/> Office Other _____ <input type="checkbox"/> Home Lower Extremity Exercises <input type="checkbox"/> Home Ice Pack <input type="checkbox"/> Bed Rest <input type="checkbox"/> Gym Lower Extremity Exercises <input type="checkbox"/> MD <input type="checkbox"/> Exam <input type="checkbox"/> MRI <input type="checkbox"/> CT	<p>Pelvis/Hip/Sacrum Tx</p> <input type="checkbox"/> 98940(1)(2) Chiropractic Manip. <input type="checkbox"/> 97124 Massage _____ minutes <input type="checkbox"/> 97035 Ultrasound _____ minutes <input type="checkbox"/> 97014 Elect.Stim (unattended) <input type="checkbox"/> 97032 Elect.Stim (attended) <input type="checkbox"/> 97140 Myofascial Release <input type="checkbox"/> 97110 Ther.Exer. 1on1 _____ min <input type="checkbox"/> 97150 Ther.Exer.Group _____ min <input type="checkbox"/> 97116 Gait Training/Stair Climb <input type="checkbox"/> Office Other _____ <input type="checkbox"/> Home Pelvis/Sacrum Exercises <input type="checkbox"/> Home Ice Pack <input type="checkbox"/> Bed Rest <input type="checkbox"/> Gym Pelvis/Sacrum Exercises <input type="checkbox"/> MD <input type="checkbox"/> Exam <input type="checkbox"/> MRI <input type="checkbox"/> CT
<p>Brain Injury Plan</p> <input type="checkbox"/> 90791 Cognitive Consultation <input type="checkbox"/> 96118 Cognitive Screening <input type="checkbox"/> 90791 Hypersomnolence Consultation <input type="checkbox"/> 96118 Hypersomnolence Evaluation <input type="checkbox"/> 97532 Cognitive Training In Office _____ min. <input type="checkbox"/> Home Physical Exercise <input type="checkbox"/> Home Meditation <input type="checkbox"/> Home Cognitive Rehabilitation Exercises <input type="checkbox"/> MD Referral <input type="checkbox"/> Counseling <input type="checkbox"/> Polysomnogram <input type="checkbox"/> Avoid Stressful Activities <input type="checkbox"/> Bed Rest <input type="checkbox"/> Other _____	<p>Depression/Anxiety Plan</p> <input type="checkbox"/> Exercise <input type="checkbox"/> Meditation <input type="checkbox"/> Counseling <input type="checkbox"/> Avoid Stressful Activities <input type="checkbox"/> Natural Anti-Depressants <input type="checkbox"/> Natural Anti-Anxiety <input type="checkbox"/> Bed Rest <input type="checkbox"/> MD Referral	<p>TMJ Plan</p> <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Massage Therapy <input type="checkbox"/> Splint for Home Use <input type="checkbox"/> Home TMJ Exercises <input type="checkbox"/> Restricted TMJ Activity <input type="checkbox"/> Relaxation Exercises <input type="checkbox"/> Soft Food/Liquid Diet <input type="checkbox"/> DDS Referral
<p>Misc Plans</p> <p style="text-align: right;">_____ Office Treatments per _____</p> <p style="text-align: right;">_____ Home Treatments per _____</p> <input type="checkbox"/> Home TENS <input type="checkbox"/> Cane/Crutches/Orthotics <input type="checkbox"/> Natural Anti-Inflammatories <input type="checkbox"/> Natural Pain Relievers <input type="checkbox"/> Order Impairment Rating Re-evaluate in _____ days		

Duties Performed Under Duress at Work and Home

Patient _____ Date _____ Date of Injury _____

Initial Update

Please check all that apply to your WORK because of the accident.

- | | |
|---|--|
| <input type="checkbox"/> I go to work but work in pain
<input type="checkbox"/> I limit my work activities
<input type="checkbox"/> Bending at work hurts
<input type="checkbox"/> Stooping at work hurts
<input type="checkbox"/> Sitting at work hurts
<input type="checkbox"/> Using the Computer at work hurts
<input type="checkbox"/> Pushing at work hurts
<input type="checkbox"/> Pulling at work hurts
<input type="checkbox"/> Kneeling at work hurts
<input type="checkbox"/> I have lost status in my company
<input type="checkbox"/> I have lost job security
<input type="checkbox"/> I didn't get a promotion
<input type="checkbox"/> I don't enjoy work as much as before
<input type="checkbox"/> I doze off at work
<input type="checkbox"/> I take unpaid time off work to go to Dr.
<input type="checkbox"/> I daydream at work more than before
<input type="checkbox"/> I feel tired at work
<input type="checkbox"/> _____
<input type="checkbox"/> _____ | <input type="checkbox"/> I work in pain because I have bills to pay
<input type="checkbox"/> I can't take time off because I would lose my job
<input type="checkbox"/> I keep working so I don't lose status at company
<input type="checkbox"/> My business would fail if I took time off
<input type="checkbox"/> I believe in working even when I'm in pain
<input type="checkbox"/> I feel obligated to work even though I'm in pain
<input type="checkbox"/> My business would lose money if I took time off
<input type="checkbox"/> My work is not as good as it was before accident
<input type="checkbox"/> My boss reprimanded me for poor performance
<input type="checkbox"/> I got a different job within the same company
<input type="checkbox"/> I got a different job in another company
<input type="checkbox"/> I make less money than before the accident
<input type="checkbox"/> I cannot do the same work/job as before accident
<input type="checkbox"/> I can't concentrate as well at work
<input type="checkbox"/> I take paid time off to go to Dr.
<input type="checkbox"/> I make mistakes at work I didn't used to
<input type="checkbox"/> I hide my poor work performance from my boss
<input type="checkbox"/> _____
<input type="checkbox"/> _____ |
|---|--|

Please check all that apply to your HOME/DOMESTIC duties because of the accident.

- | | |
|---|--|
| <input type="checkbox"/> My house is not as clean now
<input type="checkbox"/> My yard is not as neat now
<input type="checkbox"/> My garden is not as productive now
<input type="checkbox"/> I do yard work, but do it in pain
<input type="checkbox"/> I cannot do my normal yard work
<input type="checkbox"/> I do house work, but do it in pain
<input type="checkbox"/> I cannot do my normal house work
<input type="checkbox"/> Doing laundry hurts me
<input type="checkbox"/> I cannot do laundry now
<input type="checkbox"/> Washing dishes hurts me
<input type="checkbox"/> I cannot wash dishes now
<input type="checkbox"/> Vacuuming hurts me
<input type="checkbox"/> I cannot vacuum now
<input type="checkbox"/> Cooking hurts me
<input type="checkbox"/> I cannot cook now
<input type="checkbox"/> Washing the car hurts me
<input type="checkbox"/> I cannot wash my car
<input type="checkbox"/> _____
<input type="checkbox"/> _____ | <input type="checkbox"/> I cannot take time off because I care for children
<input type="checkbox"/> I have _____ children ages _____
<input type="checkbox"/> I had to hire a paid housekeeper
<input type="checkbox"/> I asked someone for unpaid housekeeping help
<input type="checkbox"/> I had to hire a paid gardener
<input type="checkbox"/> I asked someone for unpaid yard work help
<input type="checkbox"/> Mowing the lawn hurts me
<input type="checkbox"/> I cannot mow the lawn
<input type="checkbox"/> Taking out the trash hurts me
<input type="checkbox"/> I cannot take out the trash
<input type="checkbox"/> I do not enjoy my gardening/yardwork like I used to
<input type="checkbox"/> I do not enjoy my housework like I used to
<input type="checkbox"/> Gardening hurts me
<input type="checkbox"/> I cannot do my gardening at all since the accident
<input type="checkbox"/> Others living with me do my share of the work now
<input type="checkbox"/> Others living with me do my share of the yard work
<input type="checkbox"/> Others living with me do my share of the gardening
<input type="checkbox"/> _____
<input type="checkbox"/> _____ |
|---|--|

Signature

Date

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School (p. 1 of 2)

Patient _____ Date _____ Date of Injury _____

Initial Update

Please check all that apply to your EXERCISE & SPORTS Activity because of the accident.

- | | |
|---|--|
| <input type="checkbox"/> My exercise was affected by this crash | <input type="checkbox"/> I have gained _____ pounds since the accident |
| <input type="checkbox"/> I go to the gym & work out in pain | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I no longer go to the gym to work out | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I run but in pain | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I no longer run | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I take walks & have pain while walking | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> I no longer take walks | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |
| <input type="checkbox"/> I used to make income at sports | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> I have lost sports income since crash | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |
| <input type="checkbox"/> I am an amateur athlete | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> I am a professional athlete | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |
| <input type="checkbox"/> _____ | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> _____ | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |

Please check all that apply to your HOBBY Activities because of the accident.

- | | |
|---|---|
| <input type="checkbox"/> My hobbies were affected by accident | <input type="checkbox"/> Hobby #3 _____ |
| <input type="checkbox"/> Hobby #1 _____ | <input type="checkbox"/> I can't do hobby #3 anymore |
| <input type="checkbox"/> I can't do hobby #1 anymore | <input type="checkbox"/> I do hobby #3 but in pain |
| <input type="checkbox"/> I do hobby #1 but in pain | <input type="checkbox"/> I have lost money from not doing #3 |
| <input type="checkbox"/> I have lost money from not doing #1 | <input type="checkbox"/> I didn't do hobby #3 for _____ weeks |
| <input type="checkbox"/> I didn't do hobby #1 for _____ weeks | <input type="checkbox"/> Hobby #4 _____ |
| <input type="checkbox"/> Hobby #2 _____ | <input type="checkbox"/> I can't do hobby #4 anymore |
| <input type="checkbox"/> I can't do hobby #2 anymore | <input type="checkbox"/> I do hobby #4 but in pain |
| <input type="checkbox"/> I do hobby #2 but in pain | <input type="checkbox"/> I have lost money from not doing #4 |
| <input type="checkbox"/> I have lost money from not doing #2 | <input type="checkbox"/> I didn't do hobby #4 for _____ weeks |
| <input type="checkbox"/> I didn't do hobby #2 for _____ weeks | <input type="checkbox"/> _____ |

Please check all that apply to your TRAVEL Activities because of the accident.

- | | |
|---|--|
| <input type="checkbox"/> Business travel was affected by crash | <input type="checkbox"/> Travel Plan #1 _____ |
| <input type="checkbox"/> Pleasure travel was affected by crash | <input type="checkbox"/> I did not go on travel plan #1 |
| <input type="checkbox"/> I hurt driving in my own car | <input type="checkbox"/> I went, but did not enjoy #1 as much |
| <input type="checkbox"/> I am in too much pain to drive | <input type="checkbox"/> I went and the accident had no effect on #1 |
| <input type="checkbox"/> I hurt when a passenger in a car | <input type="checkbox"/> Travel Plan #2 _____ |
| <input type="checkbox"/> I am in too much pain to sit in a car | <input type="checkbox"/> I did not go on travel plan #2 |
| <input type="checkbox"/> I have anxiety when I'm in a car | <input type="checkbox"/> I went, but did not enjoy #2 as much |
| <input type="checkbox"/> I hurt when I'm on an airplane | <input type="checkbox"/> I went and the accident had no effect on #2 |
| <input type="checkbox"/> I am in too much pain to travel by plane | <input type="checkbox"/> I missed time with my family/friends b/c can't travel |

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Living, & School (p. 2 of 2)

Patient _____ Date _____ Date of Injury _____

Initial Update

Please check all the DAILY LIVING Activities that cause you pain *because of the accident.*

- | | |
|---|--|
| <input type="checkbox"/> Dressing
<input type="checkbox"/> Putting on pants
<input type="checkbox"/> Putting on shoes
<input type="checkbox"/> Tying my shoes
<input type="checkbox"/> Putting on shirt
<input type="checkbox"/> Drying my hair
<input type="checkbox"/> Combing my hair
<input type="checkbox"/> Washing my hair
<input type="checkbox"/> Taking a shower
<input type="checkbox"/> Taking a bath
<input type="checkbox"/> Leaning forward
<input type="checkbox"/> Laying in bed
<input type="checkbox"/> Sitting in my favorite chair
<input type="checkbox"/> Sleeping
<input type="checkbox"/> Going out with my friends
<input type="checkbox"/> Sitting in a restaurant
<input type="checkbox"/> Shopping
<input type="checkbox"/> Driving to/from work
<input type="checkbox"/> Sitting in Church
<input type="checkbox"/> Playing with my children
<input type="checkbox"/> Caring for my children
<input type="checkbox"/> Bending at the waist
<input type="checkbox"/> Sitting in a movie theater
<input type="checkbox"/> Exercise
<input type="checkbox"/> Eating
<input type="checkbox"/> Stooping
<input type="checkbox"/> Squatting down
<input type="checkbox"/> Kneeling
<input type="checkbox"/> Brushing my teeth | <input type="checkbox"/> Riding in a car
<input type="checkbox"/> Opening a jar
<input type="checkbox"/> Lifting a pan when cooking
<input type="checkbox"/> Closing the trunk on my car
<input type="checkbox"/> Opening the garage door
<input type="checkbox"/> Using my home computer
<input type="checkbox"/> Climbing stairs
<input type="checkbox"/> Going down stairs
<input type="checkbox"/> Sexual activity
<input type="checkbox"/> Turning my head to left or right
<input type="checkbox"/> Holding my head up all day
<input type="checkbox"/> Watching TV
<input type="checkbox"/> I have pain sitting & doing nothing
<input type="checkbox"/> Talking on the phone
<input type="checkbox"/> Reading
<input type="checkbox"/> Writing
<input type="checkbox"/> Opening doors
<input type="checkbox"/> Drying with a towel after a bath or shower
<input type="checkbox"/> Life has become a chore just to do normal things
<input type="checkbox"/> It is depressing to live like this
<input type="checkbox"/> _____
<input type="checkbox"/> _____
<input type="checkbox"/> _____
<input type="checkbox"/> _____
<input type="checkbox"/> _____
<input type="checkbox"/> _____
<input type="checkbox"/> _____
<input type="checkbox"/> _____
<input type="checkbox"/> _____ |
|---|--|

Please check all that apply to your SCHOOL & EDUCATION Activities *because of the accident.*

- | | |
|--|--|
| <input type="checkbox"/> School was affected by the accident
<input type="checkbox"/> I am a student at _____
<input type="checkbox"/> I am in the _____ year/grade
<input type="checkbox"/> I was <input type="checkbox"/> full time <input type="checkbox"/> part time
<input type="checkbox"/> I am now <input type="checkbox"/> full time <input type="checkbox"/> part time
<input type="checkbox"/> I had to take fewer classes b/c of crash
<input type="checkbox"/> I missed _____ days of school
<input type="checkbox"/> I had to drop out of school b/c of crash
<input type="checkbox"/> My grades are lower since the crash | <input type="checkbox"/> I have pain carrying my school books
<input type="checkbox"/> I hurt sitting in class more than _____ minutes
<input type="checkbox"/> My neck hurts when I look down to read
<input type="checkbox"/> I don't learn as quickly as before the crash
<input type="checkbox"/> I don't learn things as well as before the crash
<input type="checkbox"/> I have difficulty concentrating in class
<input type="checkbox"/> It takes much longer to study/do my homework
<input type="checkbox"/> _____
<input type="checkbox"/> _____ |
|--|--|

Signature of Patient

Date