Symptoms

Patient _____ Date _____ Date of Injury _____

Please fill in all symptoms you currently have <u>that you did not have</u> 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 _____

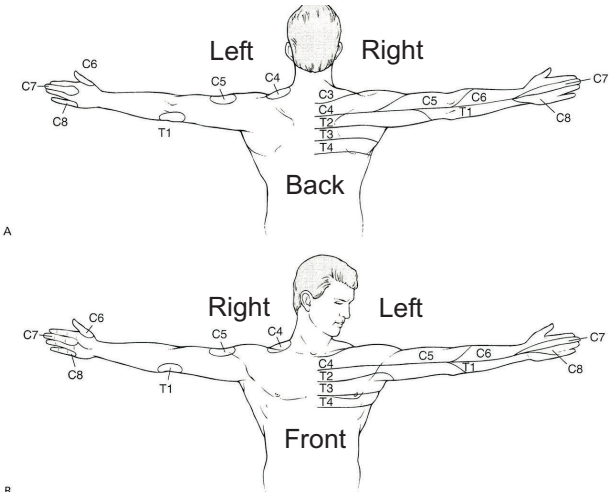
Brain/Neuropsych/MTBI Symptoms

- ☐ 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

Neck Area Consultation

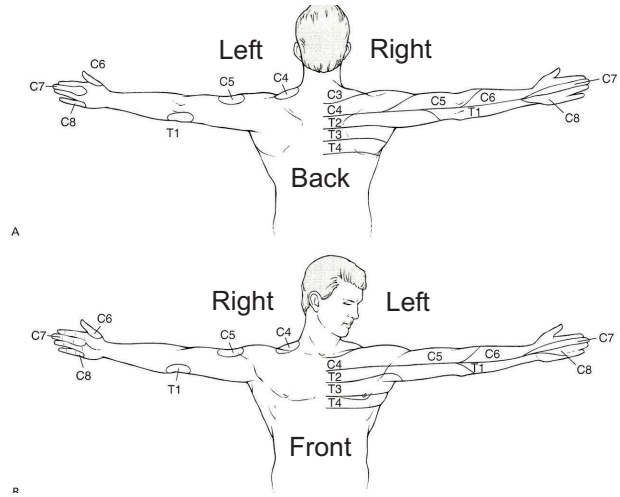
Patient _____ Today's Date _____ Date of Injury _____

Please *shade in* all areas on this picture where you have **PAIN** *in the past 7 days*



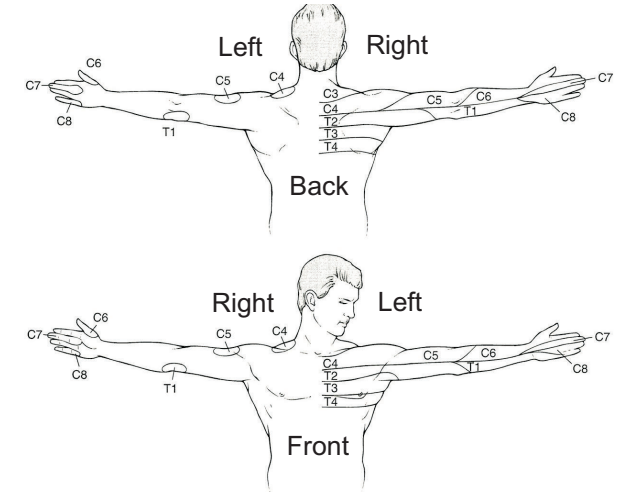
Area	Severity	% of Time	Sharp?	Dull?	Ache?	Other?
C4	/10	%				
C5	/10	%				
C6	/10	%				
C7	/10	%				
C8	/10	%				
T1	/10	%				
T2	/10	%				
T3	/10	%				
T4	/10	%				

Shade in all areas of **ALTERED SENSATION (I.E. PINS/NEEDLES, NUMB, TINGLING)** *in the past 7 days*



Area	Severity	% of Time	Pins/Needles?	Numb?	Tingling?	Other?
C4	/10	%				
C5	/10	%				
C6	/10	%				
C7	/10	%				
C8	/10	%				
T1	/10	%				
T2	/10	%				
T3	/10	%				
T4	/10	%				

Shade in all areas of **WEAKNESS, CLUMSINESS, DROPPING THINGS** *in the past 7 days*



Area	Severity	% of Time	Weak	Clumsy	Drop Things	Other
C4	/10	%				
C5	/10	%				
C6	/10	%				
C7	/10	%				
C8	/10	%				
T1	/10	%				
T2	/10	%				
T3	/10	%				
T4	/10	%				

Neck Area Consultation

Patient _____ Today's Date _____ Date of Injury _____

☐ I am having **FUNCTIONAL DIFFICULTIES** because of NECK PAIN in the past 7 days

Describe how NECK PAIN is affecting your normal daily activities _____

_____

_____

EXACERBATING FACTORS (Check all below that make your NECK hurt *more*)

☐ Laying on pillow ☐ Turning neck ☐ Looking UP ☐ Looking DOWN ☐ Combing Hair

☐ Computer at Work ☐ Computer at Home ☐ Working ☐ Sports ☐ Driving

☐ Others (please list other things that make your neck hurt) _____

_____

_____

ALLEVIATING FACTORS (Check all below that make your NECK feel *better*)

☐ Doctor Treatments Helps for _____ Hours Days Weeks Months

☐ Medications Helps for _____ Hours Days Weeks Months

☐ Home Exercises Helps for _____ Hours Days Weeks Months

☐ _____ Helps for _____ Hours Days Weeks Months

☐ _____ Helps for _____ Hours Days Weeks Months

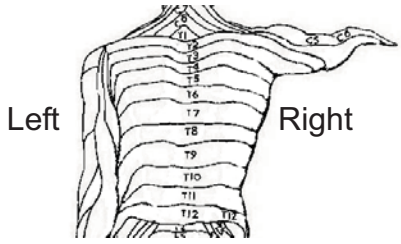
☐ _____ Helps for _____ Hours Days Weeks Months

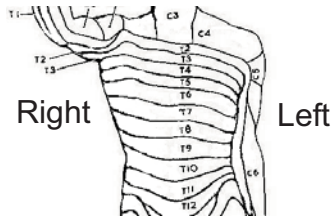
Upper Back Area Consultation

Patient _____ Today's Date _____ Date of Injury _____

Please *shade in* all areas on this picture where you have **PAIN** *in the past 7 days*

Back Side



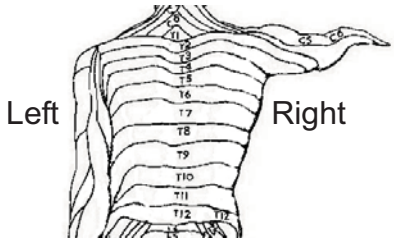


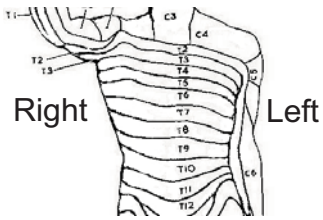
Front Side

Area	Severity	% of Time	Sharp?	Dull?	Ache?	Other?
T2	/10	%				
T3	/10	%				
T4	/10	%				
T5	/10	%				
T6	/10	%				
T7	/10	%				
T8	/10	%				
T9	/10	%				
T10	/10	%				

Shade in all areas of **ALTERED SENSATION (I.E. PINS/NEEDLES, NUMB, TINGLING)** *in the past 7 days*

Back Side





Front Side

Area	Severity	% of Time	Pins/Needles?	Numb?	Tingling?	Other?
T2	/10	%				
T3	/10	%				
T4	/10	%				
T5	/10	%				
T6	/10	%				
T7	/10	%				
T8	/10	%				
T9	/10	%				
T10	/10	%				

☐ I am having **FUNCTIONAL DIFFICULTIES** because of UPPER BACK PAIN in the past 7 days

Describe how UPPER BACK PAIN is affecting your normal daily activities _____

_____

EXACERBATING FACTORS (Check all below that make your UPPER BACK hurt *more*)

☐ Laying in Bed ☐ Sitting ☐ Bending ☐ Twisting ☐ Dressing

☐ Computer at Work ☐ Computer at Home ☐ Working ☐ Sports ☐ Driving

☐ Others (please list other things that make your UPPER BACK hurt) _____

_____

ALLEVIATING FACTORS (Check all below that make your UPPER BACK feel *better*)

☐ In-Office Treatments Helps for _____ Hours Days Weeks Months

☐ Medications Helps for _____ Hours Days Weeks Months

☐ Home Exercises Helps for _____ Hours Days Weeks Months

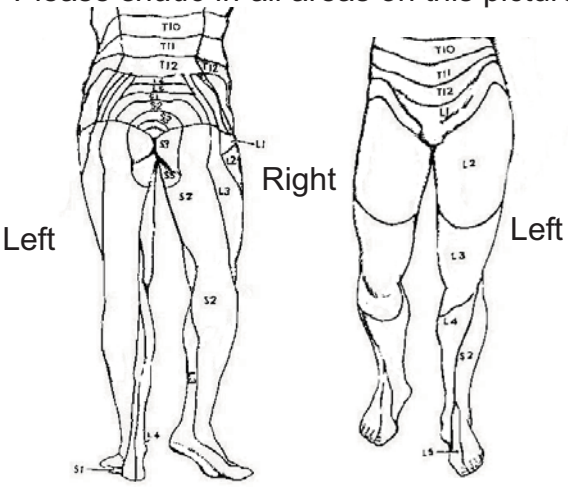
_____ Helps for _____ Hours Days Weeks Months

_____ Helps for _____ Hours Days Weeks Months

Low Back & Pelvis Area Consultation

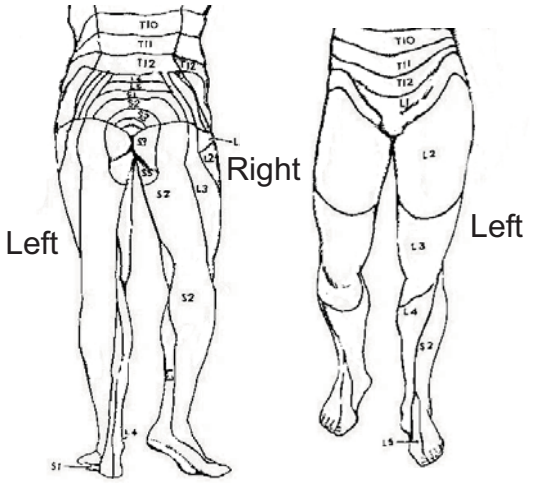
Patient _____ Today's Date _____ Date of Injury _____

Please *shade in* all areas on this picture where you have **PAIN** *in the past 7 days*



Area	Severity	% of Time	Sharp?	Dull?	Ache?	Other?
T11	/10	%				
T12	/10	%				
L1	/10	%				
L2	/10	%				
L3	/10	%				
L4	/10	%				
L5	/10	%				
S1	/10	%				
S2-5	/10	%				

Shade in all areas of **ALTERED SENSATION (I.E. PINS/NEEDLES, NUMB, TINGLING)** *in the past 7 days*



Area	Severity	% of Time	Pins/Needles?	Numb?	Tingling?	Other?
T11	/10	%				
T12	/10	%				
L1	/10	%				
L2	/10	%				
L3	/10	%				
L4	/10	%				
L5	/10	%				
S1	/10	%				
S2-5	/10	%				

☐ In my Low Back or Legs, **WEAKNESS, STUMBLING, BUMPING INTO THINGS** *in the past 7 days*

☐ I am having **FUNCTIONAL DIFFICULTIES** because of LOW BACK PAIN in the past 7 days

Describe how LOW BACK PAIN is affecting your normal daily activities _____

EXACERBATING FACTORS (Check all below that make your LOW BACK hurt *more*)

☐ Laying in Bed ☐ Sitting ☐ Bending ☐ Twisting ☐ Lifting ☐ Pushing/Pulling

☐ Computer at Work ☐ Computer at Home ☐ Working ☐ Sports ☐ Driving

☐ Others (please list other things that make your LOW BACK hurt) _____

ALLEVIATING FACTORS (Check all below that make your LOW BACK feel *better*)

☐ In-Office Treatments Helps for _____ Hours Days Weeks Months

☐ Medications Helps for _____ Hours Days Weeks Months

☐ Home Exercises Helps for _____ Hours Days Weeks Months

_____ Helps for _____ Hours Days Weeks Months

_____ Helps for _____ Hours Days Weeks Months

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/Vomithing
- ☐ 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 _____

Cervical Spine Tx

- ☐ 98940(1)(2) Chiropractic Manip.
- ☐ 97124 Massage ____ minutes
- ☐ 97035 Ultrasound ____ minutes
- ☐ 97014 ☐ 97032 Electric Stim.
- ☐ 97012 Mechanical Traction
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 ____min
- ☐ 97150 Ther.Exer.Group ____min
- ☐ Office Other _____
- ☐ Home Neck Exercises
- ☐ Home Cervical Stabilization Collar
- ☐ Home Ice Pack
- ☐ Home Cervical Traction Pillow
- ☐ Bed Rest
- ☐ Home Other _____
- ☐ Gym Neck Exercises/Activity
- ☐ MD ☐ CT ☐ MRI ☐ DMX

Thoracic Spine Tx

- ☐ 98940(1)(2) Chiropractic Manip.
- ☐ 97124 Massage ____ minutes
- ☐ 97035 Ultrasound ____ minutes
- ☐ 97014 ☐ 97032 Electric Stim.
- ☐ 97012 Mechanical Traction
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 ____min
- ☐ 97150 Ther.Exer.Group ____min
- ☐ Office Other _____
- ☐ Office Other _____
- ☐ Home Thoracic Traction Pillow
- ☐ Home Upper Back Exercises
- ☐ Home Ice Pack
- ☐ Bed Rest
- ☐ Home Other _____
- ☐ Gym Thoracic Exercises/Activity
- ☐ MD ☐ CT ☐ MRI ☐ DMX

Lumbar Spine Tx

- ☐ 98940(1)(2) Chiropractic Manip.
- ☐ 97124 Massage ____ minutes
- ☐ 97035 Ultrasound ____ minutes
- ☐ 97014 ☐ 97032 Electric Stim.
- ☐ 97012 Mechanical Traction
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 ____min
- ☐ 97150 Ther.Exer.Group ____min
- ☐ Office Other _____
- ☐ Home Low Back Exercises
- ☐ Home Ice Pack
- ☐ Home Lumbar Stabilization Belt
- ☐ Home Lumbar Traction Pillow
- ☐ Bed Rest
- ☐ Home Other _____
- ☐ Gym Lumbar Exercises/Activity
- ☐ MD ☐ CT ☐ MRI ☐ DMX

Upper Extremity Tx

- ☐ 98943 Chiropractic Manip.
- ☐ 97124 Massage ____ minutes
- ☐ 97035 Ultrasound ____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97032 Elect.Stim (attended)
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 ____min
- ☐ 97150 Ther.Exer.Group ____min
- ☐ Office Other _____
- ☐ Office Other _____
- ☐ Home Upper Extremity Exercises
- ☐ Home Ice Pack
- ☐ Bed Rest
- ☐ Gym Upper Extremity Exercises
- ☐ MD ☐ MRI ☐ CT ☐ _____

Lower Extremity Tx

- ☐ 98943 Chiropractic Manip.
- ☐ 97124 Massage ____ minutes
- ☐ 97035 Ultrasound ____ minutes
- ☐ 97014 Elect.Stim (unattended)
- ☐ 97032 Elect.Stim (attended)
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 ____min
- ☐ 97150 Ther.Exer.Group ____min
- ☐ 97116 Gait Training/Stair Climb
- ☐ Office Other _____
- ☐ Home Lower Extremity Exercises
- ☐ Home Ice Pack
- ☐ Bed Rest
- ☐ Gym Lower Extremity Exercises
- ☐ MD ☐ MRI ☐ CT ☐ _____

Pelvis/Hip/Sacrum Tx

- ☐ 98940(1)(2) Chiropractic Manip.
- ☐ 97124 Massage ____ minutes
- ☐ 97035 Ultrasound ____ minutes
- ☐ 97014 ☐ 97032 Electric Stim.
- ☐ 97012 Mechanical Traction
- ☐ 97140 Myofascial Release
- ☐ 97110 Ther.Exer. 1on1 ____min
- ☐ 97150 Ther.Exer.Group ____min
- ☐ 97116 Gait Training/Stair Climb
- ☐ Office Other _____
- ☐ Home Pelvis/Sacrum Exercises
- ☐ Home Ice Pack
- ☐ Bed Rest
- ☐ Gym Pelvis/Sacrum Exercises
- ☐ MD ☐ MRI ☐ CT ☐ _____

Brain Injury Plan

- ☐ 90801 Cognitive Consultation
- ☐ 96118 Cognitive Screening
- ☐ 90801 Hypersomnolence Consultation
- ☐ 96118 Hypersomnolence Evaluation
- ☐ 97532 Cognitive Training In Office _____ min.
- ☐ Home Physical Exercise
- ☐ Home Meditation
- ☐ Home Cognitive Rehabilitation Exercises
- ☐ MD Referral
- ☐ Counseling
- ☐ Polysomnogram
- ☐ Avoid Stressful Activities
- ☐ Bed Rest
- ☐ Other _____

Depression/Anxiety Plan

- ☐ Exercise
- ☐ Meditation
- ☐ Counseling
- ☐ Avoid Stressful Activities
- ☐ Natural Anti-Depressants
- ☐ Natural Anti-Anxiety
- ☐ Bed Rest
- ☐ MD Referral

TMJ Plan

- ☐ Physiotherapy
- ☐ Massage Therapy
- ☐ Splint for Home Use
- ☐ Home TMJ Exercises
- ☐ Restricted TMJ Activity
- ☐ Relaxation Exercises
- ☐ Soft Food/Liquid Diet
- ☐ DDS Referral

Misc Plans

____ Office Treatments per _____

____ Home Treatments per _____

- ☐ Home TENS
- ☐ Cane/Crutches/Orthotics
- ☐ Natural Anti-Inflammatories
- ☐ Natural Pain Relievers
- ☐ 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*.

- ☐ I go to work but work in pain
- ☐ I limit my work activities
- ☐ Bending at work hurts
- ☐ Stooping at work hurts
- ☐ Sitting at work hurts
- ☐ Using the Computer at work hurts
- ☐ Pushing at work hurts
- ☐ Pulling at work hurts
- ☐ Kneeling at work hurts
- ☐ I have lost status in my company
- ☐ I have lost job security
- ☐ I didn't get a promotion
- ☐ I don't enjoy work as much as before
- ☐ I doze off at work
- ☐ I take unpaid time off work to go to Dr.
- ☐ I daydream at work more than before
- ☐ I feel tired at work
- ☐ _____
- ☐ _____

- ☐ I work in pain because I have bills to pay
- ☐ I can't take time off because I would lose my job
- ☐ I keep working so I don't lose status at company
- ☐ My business would fail if I took time off
- ☐ I believe in working even when I'm in pain
- ☐ I feel obligated to work even though I'm in pain
- ☐ My business would lose money if I took time off
- ☐ My work is not as good as it was before accident
- ☐ My boss reprimanded me for poor performance
- ☐ I got a different job within the same company
- ☐ I got a different job in another company
- ☐ I make less money than before the accident
- ☐ I cannot do the same work/job as before accident
- ☐ I can't concentrate as well at work
- ☐ I take paid time off to go to Dr.
- ☐ I make mistakes at work I didn't used to
- ☐ I hide my poor work performance from my boss
- ☐ _____
- ☐ _____

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

- ☐ My house is not as clean now
- ☐ My yard is not as neat now
- ☐ My garden is not as productive now
- ☐ I do yard work, but do it in pain
- ☐ I cannot do my normal yard work
- ☐ I do house work, but do it in pain
- ☐ I cannot do my normal house work
- ☐ Doing laundry hurts me
- ☐ I cannot do laundry now
- ☐ Washing dishes hurts me
- ☐ I cannot wash dishes now
- ☐ Vacuuming hurts me
- ☐ I cannot vacuum now
- ☐ Cooking hurts me
- ☐ I cannot cook now
- ☐ Washing the car hurts me
- ☐ I cannot wash my car
- ☐ _____
- ☐ _____

- ☐ I cannot take time off because I care for children
- ☐ I have _____ children ages _____
- ☐ I had to hire a paid housekeeper
- ☐ I asked someone for unpaid housekeeping help
- ☐ I had to hire a paid gardener
- ☐ I asked someone for unpaid yard work help
- ☐ Mowing the lawn hurts me
- ☐ I cannot mow the lawn
- ☐ Taking out the trash hurts me
- ☐ I cannot take out the trash
- ☐ I do not enjoy my gardening/yardwork like I used to
- ☐ I do not enjoy my housework like I used to
- ☐ Gardening hurts me
- ☐ I cannot do my gardening at all since the accident
- ☐ Others living with me do my share of the work now
- ☐ Others living with me do my share of the yard work
- ☐ Others living with me do my share of the gardening
- ☐ _____
- ☐ _____

_____ _____

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*.

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

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

- ☐ My hobbies were affected by accident
- ☐ Hobby #1 _____
- ☐ I can't do hobby #1 anymore
- ☐ I do hobby #1 but in pain
- ☐ I have lost money from not doing #1
- ☐ I didn't do hobby #1 for _____ weeks
- ☐ Hobby #2 _____
- ☐ I can't do hobby #2 anymore
- ☐ I do hobby #2 but in pain
- ☐ I have lost money from not doing #2
- ☐ I didn't do hobby #2 for _____ weeks
- ☐ Hobby #3 _____
- ☐ I can't do hobby #3 anymore
- ☐ I do hobby #3 but in pain
- ☐ I have lost money from not doing #3
- ☐ I didn't do hobby #3 for _____ weeks
- ☐ Hobby #4 _____
- ☐ I can't do hobby #4 anymore
- ☐ I do hobby #4 but in pain
- ☐ I have lost money from not doing #4
- ☐ I didn't do hobby #4 for _____ weeks
- ☐ _____

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

- ☐ Business travel was affected by crash
- ☐ Pleasure travel was affected by crash
- ☐ I hurt driving in my own car
- ☐ I am in too much pain to drive
- ☐ I hurt when a passenger in a car
- ☐ I am in too much pain to sit in a car
- ☐ I have anxiety when I'm in a car
- ☐ I hurt when I'm on an airplane
- ☐ I am in too much pain to travel by plane
- ☐ Travel Plan #1 _____
- ☐ I did not go on travel plan #1
- ☐ I went, but did not enjoy #1 as much
- ☐ I went and the accident had no effect on #1
- ☐ Travel Plan #2 _____
- ☐ I did not go on travel plan #2
- ☐ I went, but did not enjoy #2 as much
- ☐ I went and the accident had no effect on #2
- ☐ 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*.

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

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

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

_____ _____

Signature of Patient Date