



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:

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