INJURY REPORT Initial Follow-up

Patient: ______________________ DOB: ______________

Claim/Case Number: ______________ Insurance: ______________________

Type of injury: motor vehicle work related other ______________________

Date of injury: __________ Date reported: __________ Employer: ______________

Passenger Driver Wearing seat belt: yes no Air bag triggered: yes no

Injury while wearing: back brace helmet gloves mask goggles other

Vehicle's impact site: front rear driver side passenger side

Injury to: Head Neck Chest Abdomen Back R L Arm R L Leg

Symptom(s) onset: immediate 24-48 hrs ≥48 hrs Previous similar injury? yes no

At this visit symptoms are: Absent Improved Unchanged Worse Pain 0/10

Subjective: ____

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Objective: ____

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Imaging or
lab ordered: ____

Treatment: ____

Last day at work: __________ Return to work: ______________________

Restrictions: ____

Still under care for same condition: yes no Anticipate surgery? yes no

Referred to: ____

Disability: partial total from __________ to __________

______________________ Date __________