Mode of Injury

Name: **Chart #:** **Today's Date:** **Date of Onset:**

Complete This Section if Injuries are a Result of a Work Related Accident. **Time of Injury:**

My injury occurred while I was...

☐ Carrying an object and lost my balance ☐ Driving ☐ Lifting an object.
☐ Struck by a falling object _____
☐ Engaged in a repetitive motion activity. _____
☐ Other: _____

Did you report this incident in writing at work?

☐ Yes ☐ No

Person reported to: _____ **Date reported:** _____

Did you see another health care provider for treatment related to this injury?

☐ Yes ☐ No

If you were injured by lifting, please complete all of the items which apply in the box below.

I was lifting the object:

☐ from the floor
☐ from a surface over my head
☐ from a surface about waist high

While I was lifting, I:

☐ had my back straight
☐ had my waist bent
☐ was twisted to the side

The object I was lifting was about:

☐ 2 - 5 pounds
☐ 5 - 10 pounds
☐ 10 - 15 pounds
☐ 15 - 20 pounds
☐ 20 - 25 pounds
☐ 25 - 50 pounds
☐ More than 50 pounds

The pain I felt immediately after the injury was:

☐ a dull ache ☐ a sharp pain with radiation of symptoms
☐ a grabbing feeling
☐ a popping feeling
☐ a sharp pain in one spot

If you were injured by falling, please complete the items in the box below.

I fell:

☐ from a surface 2-4 feet high
☐ from a surface 4-6 feet high
☐ from a surface 6-8 feet high
☐ from a surface higher than 8 feet
☐ onto surface I was walking on

When I fell I hit my:

☐ Back ☐ Right hand/wrist
☐ Left elbow ☐ Head
☐ Right elbow ☐ Left knee
☐ Face ☐ Right knee
☐ Left hand/wrist ☐ Tail bone

The surface I fell on can be described as:

☐ Containing an object that caused the fall ☐ Icy ☐ Wet
☐ Slick due to liquid
☐ Uneven carpet

I landed on:

☐ Back ☐ Left side
☐ Knees ☐ Right side
☐ Rear end ☐ Stomach
☐ Outstretched arms

Complete this section if your injuries were NOT work related or auto accident related.

My injury occurred when I:

☐ coughed or sneezed ☐ straightened from bending ☐ slipped and fell
☐ looked over my shoulder ☐ twisted at the waist

Injury occurred at:

☐ Home ☐ Retail store ☐ Work
☐ Mall ☐ Supermarket

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The family history has been reviewed and found to:

☐ be non-contributory to current conditions ☐ Previous Injury - Resolved ☐ Long Interim Time
☐ further evaluation needed ☐ Exacerbation ☐ Previous Care Ineffective
☐ Underlying Condition ☐ Chronic

Before the injury, how was the patient's health? _____

Does the patient feel it will improve with time? _____
Is there a time of the day the patient feels worse? _____
Has the patient has experienced similar symptoms before the injury? _____
Has the patient had new injuries involving the area of the current injury? _____

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: