On-The-Job Injury Report

Personal Injury and Industrial Accident Clinic
4211 Holladay Blvd. Salt Lake City, Utah 84124
(801) 272-8471

PERSONAL

NAME: _____ TODAY'S DATE _____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

HOME PHONE_____ CELL PHONE _____ WORK PHONE: _____

EMAIL_____(This will not be given to anyone)

AGE: ____ BIRTH DATE _____ SEX ____ HEIGHT ____ WEIGHT ____ S.S # _____

MARITAL STATUS M D W N # OF CHILDREN_____ AGES: _____

SPOUSES NAME: _____ DAY PHONE: _____

EMERGENCY PERSON TO CALL _____ PHONE: _____

REFERRED BY?

EMPLOYMENT

EMPLOYER: _____

ADDRESS: _____

CITY: _____ _____ STATE: _____ ZIP: _____

TELEPHONE:_____ HOURS: _____

SUPERVISIOR: _____ PHONE: _____

DESCRIBE YOUR REGULAR WORK DUTIES:

DOES THIS WORK GIVE YOU ANY BACK, NECK OR JOINT PAIN? Y N EXPLAIN:

INDUSTRIAL INSURANCE

CARRIER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_____

ADJUSTOR'S NAME: _____ PHONE: _____

CLAIM #:_____

INJURY DETAILS

DETAILS OF THE ACCIDENT/INJURY: (include how much you were lifting, whether it was a part of your normal activities, if you fell , how far, how you landed, etc.)_____

DATE: _____ TIME: _____ Did your report this to your supervisor immediately? Y N

Have you notified the Insurance Company? Y N

Have you missed any work? Y N How many days? _____ Can you return for: Partial Duty? Y N Full Duty? Y N

When can you return? _____

PROBLEM LIST:
Please summarize what problem(s) brought you to visit our office. (You may check more than one category).

PROBLEM	DATE PROBLEM STARTED
_____Headaches	_____
_____Neck pain	_____
_____Left Arm Pain	_____
_____Mid-Back Pain	_____
_____Lower Back Pain	_____
_____Left Leg Pain	_____
_____Right Arm Pain	_____
_____Right Leg Pain	_____
_____Other	_____

YOUR SYMPTOMS:
With this present episode of pain, was the onset gradual or sudden?

Please indicate how each of the following effects your pain by using - for decreases, + for increases, 0 for no difference and ? for don't know.

_____ walking	_____ sleeping	_____ Sexual activities
_____ sitting	_____ fatigue	_____ bending
_____ standing	_____ tension	_____ working
_____ reclining	_____ exercise	_____ housecleaning
_____ coughing	_____ sneezing	_____ bowel movements
_____ alcohol	_____ lifting	_____ medications

_____ others _____

What aspect of your pain, or which pain, is the most bothersome to you and why?

Do you have any associated symptoms such as headaches, nausea, or vomiting?

How often do you have to stop your activities and sit down or lie down to control your pain?
_____occasionally _____approximately once per day _____several times each day

_____I spend almost all day lying or sitting to control my pain.

PAIN RATION
At this time, which item best describes the ratio between pain in your neck/arm or back/leg (if applicable)?

For Neck Pain
____a. 100% neck pain; 0% arm pain
____b. 75% neck pain; 25% arm pain
____c. 50% neck pain; 50% arm pain
____d. 25% neck pain; 75% arm pain
____e. 0% neck pain; 100% arm pain

For Back Pain
____a. 100% back pain; 0% leg pain
____b. 75% back pain; 25% leg pain
____c. 50% back pain; 50% leg pain
____d. 25% back pain; 75% leg pain
____e. 0% back pain; 100% leg pain

PAIN DESCRIPTION:

SEVERITY OF PAIN: On a scale of 0 to 10 with 0 representing no pain whatsoever while 10 would be the most severe pain imaginable (suicidal pain), which number would describe your pain:

What is your pain like today?	0 1 2 3 4 5 6 7 8 9 10
What is your least pain?	0 1 2 3 4 5 6 7 8 9 10
What is your worst pain?	0 1 2 3 4 5 6 7 8 9 10

How much time during an average day are you in pain?

____less than 1 hour per day
____between 1 and 4 hours per day
____between 4 and 8 hours per day
____almost any time that I am not lying down.
____almost 24 hours per day

Mark with an "X" by the worst and best times of day for your pain:

Most Pain	Least Pain
_____ First Awakening	_____First Awakening
_____ Morning	_____ Morning
_____ Mid-day	_____ Mid-day
_____ Afternoon	_____ Afternoon
_____ Evening	_____ Evening
_____ Night time(falling asleep)	_____ Night time (falling asleep)

_____Time of day not related to pain

I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME, AND THAT I AM PERSONALLY RESPONSIBLE FOR ALL REFERRALS, INSURANCE FOLLOW-UP, AND PAYMENTS.

PATIENT'S SIGNATURE: _____ **DATE:** _____