# Patient Information and Injury History Form

Date of Exam: 0 1 2 3 4 5 6 7 8 9 Mo. Day Yr.

## Patient/Insured's Information

**Patient** First Name: | M.I. | Last Name:

☐ *Male* ☐ *Female* | Date of Birth: | Social Security Number:

**Insured's** First Name: | M.I. | Insured's Last Name:

☐ *Male* ☐ *Female* | Insured's DOB | Insured's SS#

Address: | City:

State: | Zip: | Home Phone Number:

## Insurance Company

**Primary Insurance Carrier:** | Policy # | Claim #

Address: | City:

State: | Zip: | Insurance Co. Phone Number:

**Secondary Insurance Carrier:** | Policy # | Claim #

Address: | City:

State: | Zip: | Insurance Co. Phone Number:

## Attorney Information

Attorney Name:

Address: | City:

State: | Zip: | Insured's Home Phone Number:

## Employer Information

Employer Name:

Address: | City:

State: | Zip: | Group # | Phone Number:

Date of Injury: 0 1 2 3 4 5 6 7 8 9 Mo. Day Yr.

Time of Injury: 0 1 2 3 4 5 6 7 8 9 Hour Min. ☐AM ☐PM

Date of 1st Treatment: 0 1 2 3 4 5 6 7 8 9 Mo. Day Yr.

***What type of injury?***

☐ Auto Accident
☐ Work Comp Injury
☐ Other Injury

## History of Injury:

In your own words, please briefly describe your injury:

## Previous Conditions and Treatment:

In your own words, please briefly list any previous medical conditions and treatment:

# Activities of Daily Living Form

**Mark all of the below functions that you are unable to perform or are having difficulty performing due to each of the conditions indicated above.**

| | General Symptoms | Head Condition | Shoulder Condition | Chest Condition | Abdominal Condition | Foot/Ankle Condition | Neck Condition | Mid Back Condition | Arm Condition | Low Back Condition | Hand Condition | Hip/Leg Condition |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | |  |  |  |  |  |  |  |  |  |  |  |
| **Personal Care** | | | | | | | | | | | | |
| Eating: | | | | | | | | | | | | |
| Dressing: | | | | | | | | | | | | |
| Grooming: | | | | | | | | | | | | |
| Bathing: | | | | | | | | | | | | |
| Eliminating: | | | | | | | | | | | | |
| **Communication** | | | | | | | | | | | | |
| Hearing: | | | | | | | | | | | | |
| Speaking: | | | | | | | | | | | | |
| Reading: | | | | | | | | | | | | |
| Writing: | | | | | | | | | | | | |
| Using a keyboard: | | | | | | | | | | | | |
| **Activity** | | | | | | | | | | | | |
| Sleeping: | | | | | | | | | | | | |
| Standing: | | | | | | | | | | | | |
| Walking: | | | | | | | | | | | | |
| Sitting: | | | | | | | | | | | | |
| Running: | | | | | | | | | | | | |
| Working: | | | | | | | | | | | | |
| Heavy lifting: | | | | | | | | | | | | |
| Medium lifting: | | | | | | | | | | | | |
| Light lifting: | | | | | | | | | | | | |
| Lifting weights: | | | | | | | | | | | | |
| having sex: | | | | | | | | | | | | |
| during sports: | | | | | | | | | | | | |
| Working around house: | | | | | | | | | | | | |
| Working on hobbies: | | | | | | | | | | | | |
| Exercising: | | | | | | | | | | | | |
| **Sensory** | | | | | | | | | | | | |
| Hearing: | | | | | | | | | | | | |
| Seeing: | | | | | | | | | | | | |
| Feeling: | | | | | | | | | | | | |
| Tasting: | | | | | | | | | | | | |
| Smelling: | | | | | | | | | | | | |
| **Recreation/Travel** | | | | | | | | | | | | |
| Driving a car: | | | | | | | | | | | | |
| Riding in a car: | | | | | | | | | | | | |
| Riding in a boat: | | | | | | | | | | | | |
| Traveling in an airplane: | | | | | | | | | | | | |
| Traveling in a train: | | | | | | | | | | | | |
| **Social Activities** | | | | | | | | | | | | |
| Participating in group activities: | | | | | | | | | | | | |
| Speaking in public: | | | | | | | | | | | | |
| Emotional Stability: | | | | | | | | | | | | |
| **Other** | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |

OFFICE OF INSURANCE REGULATION
*Bureau of Property & Casualty Forms and Rates*

## Standard Disclosure and Acknowledgement Form
## Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

| _____ | _____ | _____ |
|---|---|---|
| Name *(PRINT or TYPE)* | Signature | Date |

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately,** and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled,** or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**)*:

| _____ | _____ | _____ |
|---|---|---|
| Name *(PRINT or TYPE)* | Signature | Date |

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

**OIR-B1-1571**
**Pub. 1/2004**

# Patient Symptoms Form

**(Please mark as many symptoms or complaints below in up to 5 separate regions)**

Date: 0 1 2 3 4 5 6 7 8 9 — Mo. Day Yr.

Patient's Signature

Symptom Number: ☐1 ☐2 ☐3 ☐4 ☐5

## GENERAL SYMPTOMS: *(Mark as many as apply)*

| | | |
|---|---|---|
| ☐ Nervousness | ☐ Irritability | ☐ Fatigue |
| ☐ Depression | ☐ Loss of Sleep | ☐ Tension |
| ☐ PMS | ☐ Jaw Pain | |

Symptom Number: ☐1 ☐2 ☐3 ☐4 ☐5

## HEAD: *(Mark as many as apply)*

Headaches: ☐ Sharp ☐ Dull ☐ Migraine

Location: ☐ Back of head ☐ Forehead ☐ Temples ☐ Behind eyes ☐ Right side ☐ Left side

☐ Light headed ☐ Memory loss ☐ Fainting
☐ Blurred vision ☐ Double vision ☐ Sensitivity to light
☐ Balance loss ☐ Hearing loss ☐ Ringing in ears

▼No Pain — Extreme Pain▼
*Pain level:* ☐☐☐☐☐☐☐☐☐☐
*Frequency:* ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Symptom Number: ☐1 ☐2 ☐3 ☐4 ☐5

## SHOULDERS: *(Mark as many as apply)*

| | Right | Left | Both |
|---|---|---|---|
| Pain in joint: | ☐ | ☐ | ☐ |
| Pain across shoulder: | ☐ | ☐ | ☐ |
| Limitation of movement: | ☐ | ☐ | ☐ |
| Tension: | ☐ | ☐ | ☐ |

▼No Pain — Extreme Pain▼
*Pain level:* ☐☐☐☐☐☐☐☐☐☐
*Frequency:* ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Symptom Number: ☐1 ☐2 ☐3 ☐4 ☐5

## CHEST: *(Mark as many as apply)*

| | Right | Left | Both |
|---|---|---|---|
| Pain around ribs: | ☐ | ☐ | ☐ |
| Deep chest pain: | ☐ | ☐ | ☐ |

☐ Shortness of breath: ☐ Irregular heartbeat:

▼No Pain — Extreme Pain▼
*Pain level:* ☐☐☐☐☐☐☐☐☐☐
*Frequency:* ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Symptom Number: ☐1 ☐2 ☐3 ☐4 ☐5

## ABDOMINAL: *(Mark as many as apply)*

| | | |
|---|---|---|
| ☐ Nervous stomach | ☐ Nausea | ☐ Gas |
| ☐ Constipation | ☐ Diarrhea | ☐ Heartburn |
| ☐ Indigestion | ☐ Loss of appetite | ☐ Pain |

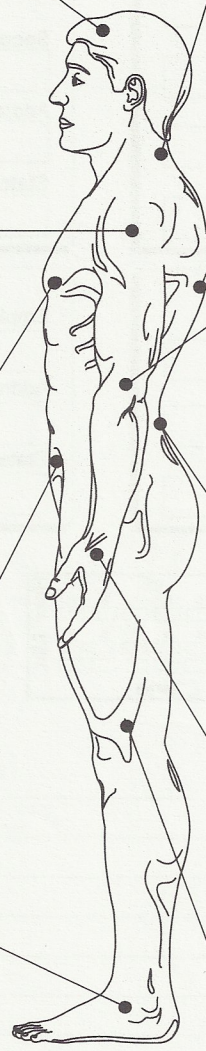
*Pain:* ▼No Pain — Extreme Pain▼ ☐☐☐☐☐☐☐☐☐☐
*Frequency:* ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Symptom Number: ☐1 ☐2 ☐3 ☐4 ☐5

## FEET: *(Mark as many as apply)*

| | Right | Left | Both |
|---|---|---|---|
| Ankle Pain: | ☐ | ☐ | ☐ |
| Swollen Ankle: | ☐ | ☐ | ☐ |
| Foot Pain: | ☐ | ☐ | ☐ |
| Numbness of Feet: | ☐ | ☐ | ☐ |
| Swollen Feet: | ☐ | ☐ | ☐ |
| Cramps: | ☐ | ☐ | ☐ |

▼No Pain — Extreme Pain▼
*Pain level:* ☐☐☐☐☐☐☐☐☐☐
*Frequency:* ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%



Symptom Number: ☐1 ☐2 ☐3 ☐4 ☐5

## NECK: *(Mark as many as apply)*

☐ Pain ☐ Left side ☐ Right side ☐ Both

*Pain increased by:*
☐ Forward mvmnt ☐ Backward mvmnt
☐ Rotate head left ☐ Rotate head right
☐ Bend neck left ☐ Bend neck right

☐ Stiffness ☐ Mus. Spasm ☐ Grinding/ Grating Sounds

▼No Pain — Extreme Pain▼
*Pain level:* ☐☐☐☐☐☐☐☐☐☐
*Frequency:* ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Symptom Number: ☐1 ☐2 ☐3 ☐4 ☐5

## MIDBACK: *(Mark as many as apply)*

| | Right | Left | Both |
|---|---|---|---|
| Pain: | ☐ | ☐ | ☐ |
| Muscle Spasm: | ☐ | ☐ | ☐ |

▼No Pain — Extreme Pain▼
*Pain level:* ☐☐☐☐☐☐☐☐☐☐
*Frequency:* ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Symptom Number: ☐1 ☐2 ☐3 ☐4 ☐5

## ARM: *(Mark as many as apply)*

| | Right | Left | Both |
|---|---|---|---|
| Pain in Upper Arm: | ☐ | ☐ | ☐ |
| Pain in Elbow: | ☐ | ☐ | ☐ |
| Pain in Forearm: | ☐ | ☐ | ☐ |
| Pins & Needles (Arm): | ☐ | ☐ | ☐ |
| Pins & Needles (Forearm): | ☐ | ☐ | ☐ |
| Numbness in Arm: | ☐ | ☐ | ☐ |
| Numbness in Forearm: | ☐ | ☐ | ☐ |

▼No Pain — Extreme Pain▼
*Pain level:* ☐☐☐☐☐☐☐☐☐☐
*Frequency:* ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Symptom Number: ☐1 ☐2 ☐3 ☐4 ☐5

## LOWBACK: *(Mark as many as apply)*

| | Right | Left | Both |
|---|---|---|---|
| Upper Lumbar Pain: | ☐ | ☐ | ☐ |
| Lower Lumbar Pain: | ☐ | ☐ | ☐ |
| Sacro-iliac Pain: | ☐ | ☐ | ☐ |
| Muscle Spasm: | ☐ | ☐ | ☐ |

▼No Pain — Extreme Pain▼
*Pain level:* ☐☐☐☐☐☐☐☐☐☐
*Frequency:* ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Symptom Number: ☐1 ☐2 ☐3 ☐4 ☐5

## HAND: *(Mark as many as apply)*

| | Right | Left | Both |
|---|---|---|---|
| Pain in Wrist: | ☐ | ☐ | ☐ |
| Pain in Hand: | ☐ | ☐ | ☐ |
| Pins & Needles (Hand): | ☐ | ☐ | ☐ |
| Numbness (Hand): | ☐ | ☐ | ☐ |

▼No Pain — Extreme Pain▼
*Pain level:* ☐☐☐☐☐☐☐☐☐☐
*Frequency:* ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Symptom Number: ☐1 ☐2 ☐3 ☐4 ☐5

## HIPS & LEGS: *(Mark as many as apply)*

| | | |
|---|---|---|
| Pain in Buttocks: | Location- | ☐ Right ☐ Left ☐ Both |
| Pain in Hip Joint: | Location- | ☐ Right ☐ Left ☐ Both |
| Pain Down Leg: | Location- | ☐ Right ☐ Left ☐ Both |
| | Region- | ☐ Front ☐ Back ☐ Side |
| | Radiates to- | ☐ Knee ☐ Calf ☐ Foot |
| Numbness Down Leg: | Location- | ☐ Right ☐ Left ☐ Both |
| | Region- | ☐ Front ☐ Back ☐ Side |
| Pins & Needles (Leg): | Location- | ☐ Right ☐ Left ☐ Both |
| | Region- | ☐ Front ☐ Back ☐ Side |
| Knee Pain: | Location- | ☐ Right ☐ Left ☐ Both |
| Leg Cramps: | Location- | ☐ Right ☐ Left ☐ Both |

▼No Pain — Extreme Pain▼
*Pain level:* ☐☐☐☐☐☐☐☐☐☐
*Frequency:* ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

***Please mark all actions that AGGRAVATE the above conditions:***

| | Bending | Twisting | Lifting | Walking | Sitting | Lying Down | Coughing | Straining | Sneezing |
|---|---|---|---|---|---|---|---|---|---|
| *Symptom #1* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| *Symptom #2* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| *Symptom #3* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| *Symptom #4* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| *Symptom #5* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

***Please mark areas of radiating pain from any of the above 5 areas of complaint:***

| | Bilat. | Left | Right | Head | Neck | Shoulders | Arm | Hand | Mid Back | Low Back | Hip | Leg | Knee | Calf | Foot |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Symptom #1* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| *Symptom #2* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| *Symptom #3* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| *Symptom #4* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| *Symptom #5* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Auto Accident Info:

▶ ***What was your position in the vehicle?***

☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian (not in car)

▶ ***What type of vehicle were you driving?***

☐ Compact Car ☐ Mid Size Car ☐ Full Size Car ☐ Compact Truck
☐ Full Truck ☐ Mini Van ☐ Full Size Van ☐ Small Sport Utility
☐ Lg. Sport Util. ☐ Motorcycle ☐ Motor Home ☐ Bicycle

▶ ***What was your vehicle doing just prior to the accident?***

☐ Stopped at a stop light ☐ Slowing down to a stop
☐ At a complete stop ☐ Increasing speed
☐ Merging into traffic ☐ Changing lanes

*Traveling at an approximate speed of:*

☐ 5 mph ☐ 10 mph ☐ 15 mph ☐ 20 mph ☐ 25 mph ☐ 30 mph
☐ 35 mph ☐ 40 mph ☐ 45 mph ☐ 50 mph ☐ 55 mph ☐ 60 mph
☐ 65 mph ☐ 70 mph ☐ 75 mph ☐ 80 mph ☐ Faster than 80 mph

▶ ***Who hit who?***

☐ You were struck by another car ☐ You struck another vehicle
☐ You struck a stationary object

▶ ***What was your vehicles point of impact?***

☐ Front ☐ Rear ☐ Right Side ☐ Left Side
☐ Right Front ☐ Left Front ☐ Right Rear ☐ Left Rear

▶ ***What was the other vehicle doing just prior to the accident?***

☐ Stopped at a stop light ☐ Slowing down to a stop
☐ At a complete stop ☐ Increasing speed
☐ Merging into traffic ☐ Changing lanes

*Traveling at an approximate speed of:*

☐ 5 mph ☐ 10 mph ☐ 15 mph ☐ 20 mph ☐ 25 mph ☐ 30 mph
☐ 35 mph ☐ 40 mph ☐ 45 mph ☐ 50 mph ☐ 55 mph ☐ 60 mph
☐ 65 mph ☐ 70 mph ☐ 75 mph ☐ 80 mph ☐ Faster than 80 mph

▶ ***What was the other vehicles point of impact?***

☐ Front ☐ Rear ☐ Right Side ☐ Left Side
☐ Right Front ☐ Left Front ☐ Right Rear ☐ Left Rear

▶ ***Were you wearing seat restraints?***

☐ Full lap and shoulder restraint ☐ Lap restraint only
☐ Shoulder restraint only ☐ I was not wearing a restraint

▶ ***What position were your vehicles head rests in?***

☐ Lowest position ☐ Middle position
☐ Highest position ☐ No head rest in vehicle

▶ ***Did your vehicles air bags deploy?***

☐ Yes ☐ No

▶ ***Were you prepared for the impact?***

☐ Came as complete surprise ☐ Aware and braced for collision
☐ Aware but not braced for collision

▶ ***What position was your head and neck in prior to the impact?***

☐ Straight forward ☐ Tilted forward ☐ Rotated to the left
☐ Rotated to the right ☐ Turned around ☐ Toward rear view mirror

▶ ***What happened to your body at the moment of impact?***

☐ Body was tensed for impact ☐ Body whipped forward/backward
☐ Body torqued and twisted ☐ Body was thrown over seat
☐ Body was thrown from vehicle ☐ Body was pinned in vehicle
☐ Body was thrown from side to side ☐ Body was cut and bruised

▶ ***What was your mental/emotional state immediately following?***

☐ Unconscious ☐ Shaken up
☐ Disoriented ☐ Shaken up & Disoriented

▶ ***Did you receive medical attention at the scene of the accident?***

☐ Yes ☐ No

▶ ***Where did you go immediately following the accident?***

☐ Hospital ☐ Personal Doctor ☐ This Office
☐ Home ☐ Resumed daily activities

▶ ***Mark all areas of your body that struck the below listed parts of your vehicle:***

| Right Side | Head | Neck | Shoulder | Arm | Elbow | Wrist | Hand | Chest | Stomach | Hip | Leg | Knee | Ankle | Foot | | Neck | Shoulder | Arm | Elbow | Wrist | Hand | Chest | Stomach | Hip | Leg | Knee | Ankle | Foot | Left Side |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Dashboard | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Windshield | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Steering wheel | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Right door | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Left door | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Seat frame | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Unknown object | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Work Comp Injury Info:

### If your injury involved LIFTING, complete this section:

▶ ***From where were you lifting an object?***

☐ Ground level ☐ A surface below ground level
☐ A surface 1 to 3 feet high ☐ A surface 3 to 5 feet high
☐ A surface above 5 feet high

▶ ***How many pounds was the object you were lifting?***

☐ 1 to 5 pounds ☐ 5 to 10 pounds ☐ 10 to 20 pounds
☐ 20 to 40 pounds ☐ 40 to 60 pounds ☐ Over 60 pounds

▶ ***What position were you in while lifting the object?***

☐ Back was upright and straight ☐ Bent over at the waist
☐ Twisted to the left side ☐ Twisted to the right side

▶ ***What type of pain did you feel immediately after the injury?***

☐ Gripping pain ☐ Sharp pain ☐ Dull pain
☐ Aches ☐ Popping feeling ☐ Paralysis

### If your injury involved FALLING, complete this section:

▶ ***From where did you fall at work?***

☐ Onto the ground while walking ☐ Onto the ground while running
☐ From 1 to 3 feet high ☐ From 3 to 5 feet high
☐ From 5 to 8 feet high ☐ From higher than 8 feet

▶ ***What part of your body did you land on?***

☐ Head ☐ Neck ☐ Right Shoulder ☐ Left Shoulder
☐ Right Arm ☐ Left Arm ☐ Right Hand ☐ Left Hand
☐ Back ☐ Right Buttock ☐ Left Buttock ☐ Tail Bone
☐ Right Hip ☐ Left Hip ☐ Right Leg ☐ Left Leg
☐ Right Knee ☐ Left Knee ☐ Right Foot ☐ Left Foot

▶ ***What other areas of your body were affected by your fall?***

☐ Head ☐ Neck ☐ Right Shoulder ☐ Left Shoulder
☐ Right Arm ☐ Left Arm ☐ Right Hand ☐ Left Hand
☐ Back ☐ Right Buttock ☐ Left Buttock ☐ Tail Bone
☐ Right Hip ☐ Left Hip ☐ Right Leg ☐ Left Leg
☐ Right Knee ☐ Left Knee ☐ Right Foot ☐ Left Foot

### Other work related injuries:

☐ Raised up from bending over ☐ Twisted at the waist
☐ Wrist injury from repetitive use ☐ Wrist injury from pulling

**(Please describe ALL injuries in your own words on page 1 of this form)**

### Job analysis information:

▶ ***What regular activities did you perform at work?***

☐ Sitting ☐ Standing ☐ Walking
☐ Running ☐ Driving ☐ Lifting
☐ Bending/Stooping ☐ Squatting ☐ Crawling
☐ Climbing ☐ Crouching ☐ Reach above shoulders
☐ Kneeling ☐ Pushing/Pulling ☐ Maintain awkward position

▶ ***How much do you regularly lift at your job?***

☐ Little to none ☐ 1 to 10 Lbs ☐ 10 to 20 Lbs ☐ 20 to 40 Lbs
☐ 40 to 60 Lbs ☐ 60 to 80 Lbs ☐ 80 to 100 Lbs ☐ Over 100 Lbs

▶ ***Do you regularly bend over while lifting?*** ☐ Yes ☐ No

▶ ***Are your hands subject to any of the below repetitive movements?***

☐ Light grasping (left hand) ☐ Light grasping (right hand) ☐ Light grasping both
☐ Firm grasping (left hand) ☐ Firm grasping (right hand) ☐ Firm grasping both
☐ Typing ☐ Using a computer mouse

▶ ***How many hours do you regularly perform the below activities?***

| | | | | |
|---|---|---|---|---|
| **Sitting:** | ☐ 1-2 hours | ☐ 2-4 hours | ☐ 4-6 hours | ☐ 6-8 hours |
| **Standing:** | ☐ 1-2 hours | ☐ 2-4 hours | ☐ 4-6 hours | ☐ 6-8 hours |
| **Walking:** | ☐ 1-2 hours | ☐ 2-4 hours | ☐ 4-6 hours | ☐ 6-8 hours |
| **Lifting:** | ☐ 1-2 hours | ☐ 2-4 hours | ☐ 4-6 hours | ☐ 6-8 hours |