Manual Therapist **Miller Medical Massage**

INJURY INFORMATION

Patient Name ______________________________ Date ______________

Date of Injury ______________________ **Insurance Claim#:**

A. General Injury Information

1. How did the accident occur?
☐ Auto ☐ On-the-Job ☐ Other __________

2. Was a police report filed? ☐Yes ☐ No
Was a work incident report filed?
☐Yes ☐No

3. Describe your injury and how it occurred:
____
____
____
____
____
____

4. Describe how you felt during and immediately after the injury:
____
____
Later that same day: ______________________________
____
The next day: ______________________________
____
____
The next week: ______________________________
____
The next month: ______________________________
____
Describe any bruises, cuts, or abrasions as a result of the injury:
____
____

5. Are your symptoms ☐ getting better ☐ getting worse ☐ no change
What makes them better? ______________________________
____
____
____
Worse? ______________________________
____
____

6. Did you return to work on the day of the injury? ☐ Yes ☐ No
Have you lost time from work since the injury? ☐ Yes ☐ No

7. What are your work responsibilities?
____
____
Which work activities are affected by this injury? ______________________________
____
Have your work responsibilities changed as a result of this injury? ☐ Yes ☐ No
Explain ______________________________
What other daily activities are affected by this injury? ______________________________
____
____

8. Did you go to the emergency room?
☐ Yes ☐ No
Were you hospitalized? ☐ Yes ☐ No
List the health care providers who have treated you for this injury, the type of treatment provided, and their diagnosis.
____
____
____
____

9. Have you ever had this type of injury before? ☐ Yes ☐ No
Explain ______________________________
____
Did you have any physical complaints before the injury? ☐ Yes ☐ No
Explain ______________________________
____
Do you have any illnesses or previous injuries that may have been affected by this injury? ☐ Yes ☐ No
Explain ______________________________
____

Signature ______________________________ Date ______________

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B. Motor Vehicle Accident Information

1. Did the police arrive at the accident?
   ☐ Yes ☐ No
2. How was your vehicle hit?
   ☐ Rear end ☐ Head on ☐ Side swipe
   OR Did your vehicle hit another vehicle/object?
   ☐ Rear end ☐ Head on ☐ Side swipe
   If you were hit from behind, was your vehicle pushed forward upon impact?
   ☐ Yes ☐ No If yes, how much?
   ____
   Did your vehicle hit anything else after the initial impact? ☐ Yes ☐ No
   Explain ______________________________
   ____
   ____
   ____
3. Were you at a stop or moving at the time of impact? ☐ Stopped ☐ Moving
   If you were stopped, was your foot on the brake? ☐ Yes ☐ No
   If you were moving, were you:
   ☐ Increasing speed
   ☐ Decreasing speed
   ☐ Traveling at a steady speed
   Was the other vehicle moving at the time of impact? ☐ Yes ☐ No
   If yes, was it: ☐ Increasing speed
   ☐ Decreasing speed ☐ Traveling at a steady speed
4. Where were you seated in the vehicle?
   ____
   ____
   ____
5. Which way was your head facing upon impact?
   ____
   ____
   ____
6. Were you aware of the approaching vehicle or did the impact catch you by surprise?
   ☐ Aware ☐ Surprise
7. Did you lose consciousness?
   ☐ Yes ☐ No
8. Were you wearing a seat belt? ☐ No
   ☐ Lap belt ☐ Shoulder harness ☐ Both
9. Is your vehicle equipped with an airbag?
   ☐ Yes ☐ No
   Did it activate? ☐ Yes ☐ No
10. Is the top of your head rest:
    ☐ Above your head ☐ Below your head
    Does your head touch the head rest?
    ☐ Yes ☐ No
    If no, how far in front of the head rest is your head?
    ____
11. What were the road conditions?
    ☐ Wet ☐ Dry ☐ Icy ☐ Oily
12. What type of vehicle were you in? (make, model, year)
    ____
    What type of vehicle hit you? (make, model, year)
    ____
13. Did any part of your body come into contact with the vehicle? ☐ Yes ☐ No
    Explain ______________________________
    ____
    ____
    ____
    Did any parts of the vehicle break?
    ☐ Yes ☐ No
    Explain ______________________________
    ____
    ____
    ____
14. Check all of the following symptoms that you have experienced since the accident:
    ☐ Loss of memory ______________________________
    ☐ Loss of balance ______________________________
    ☐ Visual disturbances ______________________________
    ☐ Hearing difficulties ______________________________
    ☐ Difficulty breathing ______________________________
    ☐ Sleep disturbances ______________________________
15. Anything else you want to tell me about the accident or how you feel?
    ____
    ____
    ____

Patient Signature ______________________________ Date ______________________________

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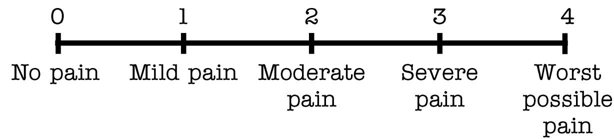
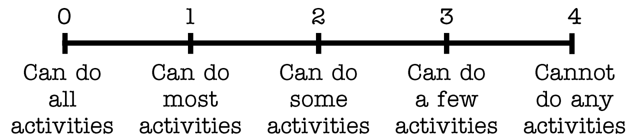
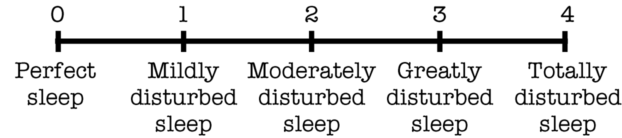
FUNCTIONAL RATING INDEX

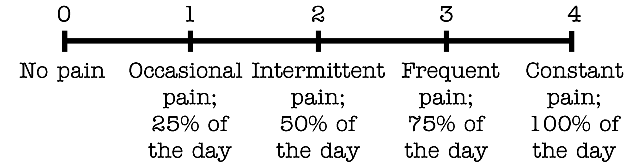
Name ______________________________ ID#/DOB ____________________ Date _____________

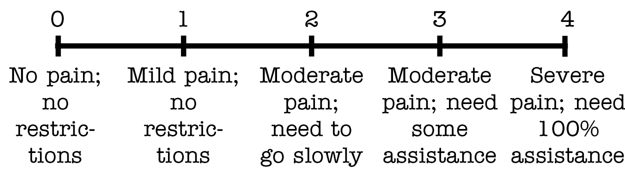
In order to properly assess your condition, we must understand how much your _____________ have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

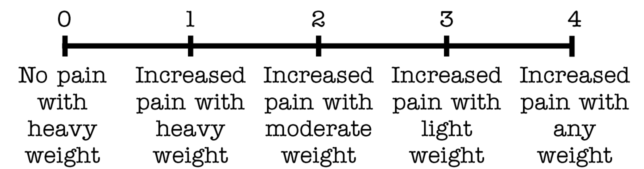


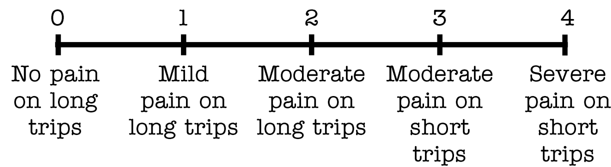


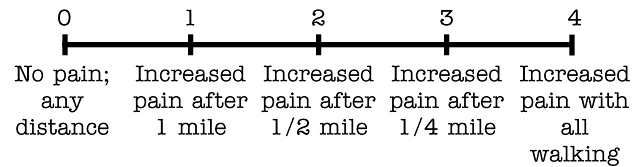


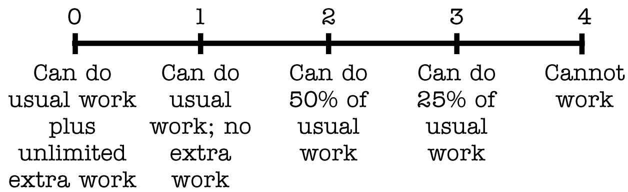


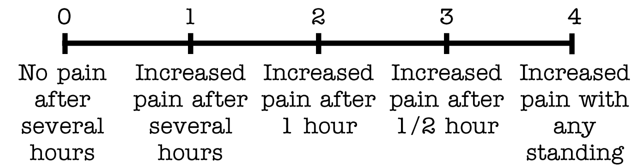












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ONLY FILL OUT THE NECK PAIN INDEX IF YOU HAVE NECK PAIN DUE TO YOUR INJURY

(revised Vernon-Mior)

NECK PAIN & DISABILITY INDEX

Patient Name ______________________________ Date ______________

Date of Injury ______________________ ID#/DOB ______________________

This questionnaire has been designed to give the health care provider information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the **ONE** box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem today.

Section 1 - Pain Intensity

☐ I have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

Section 2 - Personal Care (washing, dressing, etc.)

☐ I can look after myself normally without causing pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash myself with difficulty and I stay in bed.

Section 3 - Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it causes extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 - Reading

☐ I can read as much as I want to with no pain in my neck.
☐ I can read as much as I want to with slight pain in my neck.
☐ I can read as much as I want to with moderate pain in my neck.
☐ I can't read as much as I want to because of moderate pain in my neck.
☐ I can hardly read at all because of severe pain in my neck.
☐ I cannot read at all.

Section 5 - Headaches

☐ I have no headaches at all.
☐ I have slight headaches which come infrequently.
☐ I have moderate headaches which come infrequently.
☐ I have moderate headaches which come frequently.
☐ I have severe headaches which come frequently.
☐ I have headaches almost all of the time.

Section 6 - Concentration

☐ I can concentrate fully when I want to with no difficulty.
☐ I can concentrate fully when I want to with slight difficulty.
☐ I have a fair degree of difficulty in concentrating when I want to.
☐ I have a lot of difficulty concentrating when I want to.
☐ I have a great deal of difficulty in concentrating when I want to.
☐ I cannot concentrate at all.

Section 7 - Work

☐ I can do as much work as I want to.
☐ I can do my usual work but no more.
☐ I can do most of my usual work but no more.
☐ I cannot do my usual work.
☐ I can hardly do any work at all.
☐ I can't do any work at all.

Section 8 - Driving

☐ I can drive my car without any neck pain.
☐ I can drive my car as long as I want with slight pain in my neck.
☐ I can drive my car as long as I want with moderate pain in my neck.
☐ I can't drive my car as long as I want because of moderate pain in my neck.
☐ I can hardly drive at all because of severe pain in my neck.
☐ I can't drive my car at all.

Section 9 - Sleeping

☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed (less than 1 hour sleepless).
☐ My sleep is mildly disturbed (1–2 hours sleepless).
☐ My sleep is moderately disturbed (2–3 hours sleepless).
☐ My sleep is greatly disturbed (3–5 hours sleepless).
☐ My sleep is completely disturbed (5–7 hours sleepless).

Section 10 - Recreation

☐ I am able to engage in all my recreational activities with no neck pain at all.
☐ I am able to engage in all my recreational activities with some pain in my neck.
☐ I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
☐ I can hardly do any recreational activities because of pain in my neck.
☐ I can't do recreational activities at all.

Signature ______________________________ Date ______________

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ONLY FILL OUT THE LOW BACK PAIN INDEX IF YOU HAVE LOW BACK PAIN DUE TO YOUR INJURY

(revised Oswestry) LOW BACK PAIN & DISABILITY INDEX

Patient Name ______________________ Date __________

Date of Injury ______________ ID#/DOB ______________

This questionnaire has been designed to give the health care provider information about how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the **ONE** box which applies to you. We realize you may consider that two statements in any one section relate to you, but please just mark the box which most closely describes your problem today.

Section 1 - Pain Intensity
- ☐ The pain comes and goes and is mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

Section 2 - Personal Care
- ☐ I can look after myself normally without causing pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash myself with difficulty, and I stay in bed.

Section 3 - Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - Walking
- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than 1 mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

Section 5 - Sitting
- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases my pain straight away.

Section 6 - Standing
- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than 1 hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain straight away.

Section 7 - Sleeping
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1–2 hours sleepless).
- ☐ My sleep is moderately disturbed (2–3 hours sleepless).
- ☐ My sleep is greatly disturbed (3–5 hours sleepless).
- ☐ My sleep is completely disturbed (5–7 hours sleepless).

Section 8 - Social Life
- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I hardly have any social life because of the pain.

Section 9 - Traveling
- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

Section 10 - Changing Degree of Pain
- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at present.
- ☐ My pain is neither getting better nor getting worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Signature ______________________ Date __________

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