Manual Therapist **Miller Medical Massage**

# INJURY INFORMATION

Patient Name _____ Date _____

Date of Injury_____ **CLAIM** _____ **Date of Birth** _____

## 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 _____

**If you were injured in an Auto Accident WHILE On-the-job, please let us know ASAP. Also, please fill out page two of the Auto Injury Information Form ONLY.**

Manual Therapist **Miller Medical Massage** **HEALTH REPORT**

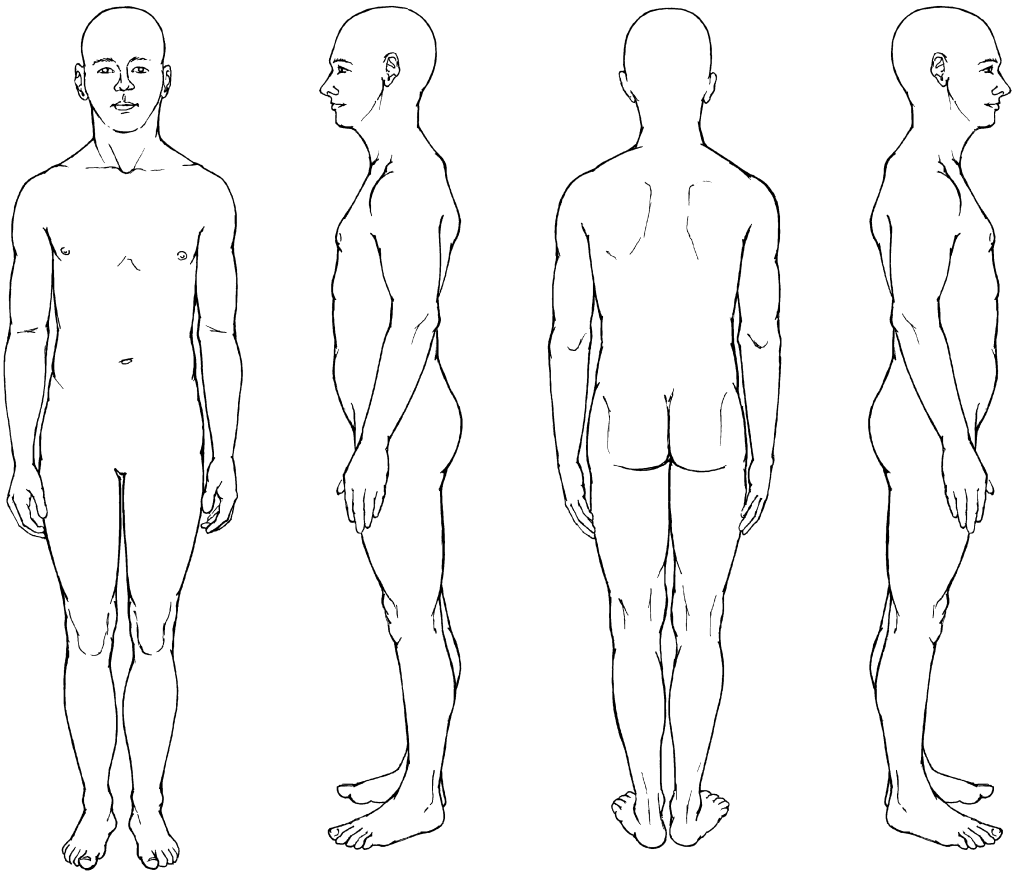
Patient Name _____ Date _____

Date of Injury _____ **CLAIM** _____ **Date of Birth** _____

**A. Draw today's symptoms on the figures.**

1. Identify CURRENT symptomatic areas in your body by marking letters on the figures below. Use the letters provided in the key to identify the symptoms you are feeling today.
2. Circle the area around each letter, representing the size and shape of each symptom location.

**Key**
P = pain or tenderness
S = joint or muscle stiffness
N = numbness or tingling



**B. Identify the intensity of your symptoms.**

1. Pain Scale: Mark a line on the scale to show the amount of pain you are experiencing today.

No Pain ——————————— Unbearable Pain

2. Activities Scale: Mark a line on the scale to show the limitations you are experiencing today in your daily activities.

Can Do Anything I Want ——————————— Cannot Do Anything

**C. Comments**

_____

_____

_____

_____

Signature _____ Date _____

**Miller Medical Massage**

# FUNCTIONAL RATING INDEX

Name _____ **CLAIM#** _____ Date _____

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

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain |

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Can do all activities | Can do most activities | Can do some activities | Can do a few activities | Cannot do any activities |

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Perfect sleep | Mildly disturbed sleep | Moderately disturbed sleep | Greatly disturbed sleep | Totally disturbed sleep |

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain | Occasional pain; 25% of the day | Intermittent pain; 50% of the day | Frequent pain; 75% of the day | Constant pain; 100% of the day |

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain; no restric-tions | Mild pain; no restric-tions | Moderate pain; need to go slowly | Moderate pain; need some assistance | Severe pain; need 100% assistance |

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain with heavy weight | Increased pain with heavy weight | Increased pain with moderate weight | Increased pain with light weight | Increased pain with any weight |

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain on long trips | Mild pain on long trips | Moderate pain on long trips | Moderate pain on short trips | Severe pain on short trips |

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain; any distance | Increased pain after 1 mile | Increased pain after 1/2 mile | Increased pain after 1/4 mile | Increased pain with all walking |

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Can do usual work plus unlimited extra work | Can do usual work; no extra work | Can do 50% of usual work | Can do 25% of usual work | Cannot work |

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain after several hours | Increased pain after several hours | Increased pain after 1 hour | Increased pain after 1/2 hour | Increased pain with any standing |

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

Miller Medical Massage

# NECK PAIN & DISABILITY INDEX (revised Vernon-Mior)

Patient Name _____ Date _____

Date of Injury _____ **CLAIM** _____ **Date of Birth** _____

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 _____

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

Miller Medical Massage

# LOW BACK PAIN & DISABILITY INDEX (revised Oswestry)

Patient Name _____ Date _____

Date of Injury _____ **CLAIM** _____ **Date of Birth** _____

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 _____