CAD Injury History Form

General information:

Patient' name: ____________________
Today's date: ____________________
Date of injury: ____________________
Marital status: ☐ M ☐ S ☐ W ☐ D
Habits:
Smoke: ☐ None Pk/day _____ Years _______
Alcohol: ☐ Never ☐ Social ☐ Light ☐ Mod. ☐ Heavy
Employment:
At time of crash: ____________________
☐ Unemployed
Currently: ____________________
☐ Unemplyed
Due to crash? ☐ Yes ☐ No
Type of work: ☐ Office/clerical ☐ Light labor ☐ Moderate labor ☐ Heavy labor

Past medical history:

Surgeries (dates and residuals): ____________________

Fractures (dates and residuals): ____________________

Serious illness (dates and residuals): ____________________

Workers' comp. injuries (date, TX, awards, residuals): ____________________

Personal Injuries (date, TX, awards, residuals):

Sports or other injuries to head, neck, or back:

Past medical history (cont'd)

Any prior HX of current complaints:
1. ____________________
2. ____________________
3. ____________________
Prior TX by DC for these:
1. ____________________
2. ____________________
3. ____________________

Current Medical history:

Current health problems: ☐ None

Current medications taken: ☐ None

Injury history. General:

Was the crash on-the-job? ☐ Yes ☐ No
You were: ☐ Driver ☐ Front seat passenger ☐ Rear seat passenger ☐ Motorcycle operator ☐ Motorcycle passenger ☐ Other __________
Vehicle driven by: ____________________
Your vehicle (year, make, model): ____________________
Your estimated speed at moment of crash: ________
☐ Stopped ☐ Slowing ☐ Accelerating
Other vehicle (year, make, model): ____________________
Time of day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark
Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other ____________
Head restraints: ☐ None ☐ Integral type ☐ Adjustable type: ☐ Up ☐ Down ☐ Don't know
If adjustable, was the position altered by the crash? ☐ Yes ☐ No
Was the seat back adjustment altered by the crash? ☐ Yes ☐ No
Was the seat broken? ☐ Yes ☐ No
Lap belt: ☐ Wearing ☐ Not wearing ☐ Don't know
Shoulder belt: ☐ None ☐ Wearing ☐ Not wearing ☐ Don't know
Did air bag deploy? ☐ Yes ☐ No
If yes, were you struck? ☐ Yes ☐ No
Body position: ☐ Good ☐ Forward lean
Other ____________________
Head position: ☐ Forward ☐ Left ____° ☐ Right ____° ☐ Up ____° ☐ Down ____°

Injury history. General: (cont'd)

Hands: ☐ One on wheel ☐ Two on wheel ☐ N/A

Brakes applied? ☐ Yes ☐ No

Crash description: ____________________

____

____

____

____

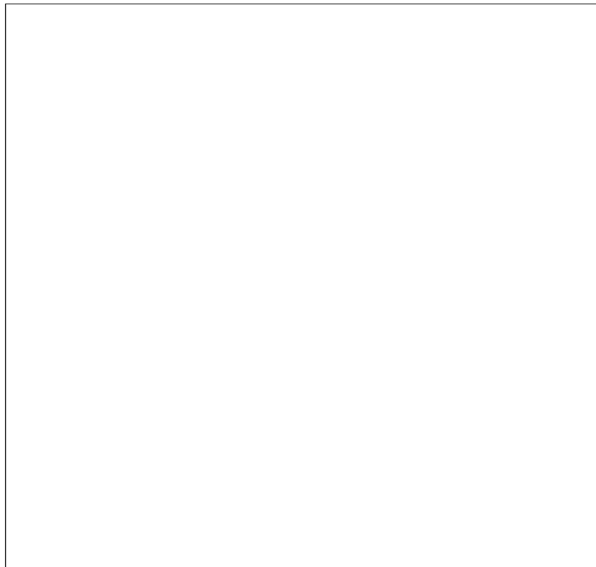
____

____

____

____

Crash diagram:



Aware of impending crash? ☐ Yes ☐ No

During the crash:

Did you strike any parts of the vehicle? ☐ Y ☐ N

If yes, describe____________________

Did vehicle strike any objects after crash?

If yes, describe____________________

Wearing hat or glasses? ☐ Yes ☐ No

If yes, still on after crash? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No

If yes, for how long?____________________

Estimated property damage to your vehicle:

$ ____________________

Estimated damage to other vehicle(s): ☐ None

☐ Minimal ☐ Moderate ☐ Major

Were the police on-scene? ☐Yes ☐No

If yes, was a report made? ☐Yes ☐No

After the crash:

Symptoms: ☐ Headache ☐ Dizziness ☐ Nausea

☐ Confusion/disorientation ☐ Neck pain

☐ Paresthesia(s)

If yes, where?____________________

☐ Extremity pain. If yes, where?____________________

☐ Back pain

When did SX first appear? ☐ Immediately

(describe which SX)____________________ hr afterward

Where did you go after crash? ☐ Home

☐ Work ☐ Hospital:

Mode of transportation ____________________

Pvt. doctor:____________________

Emergency department:

Radiographs: ☐ Yes ☐ No

Body parts imaged____________________

Results____________________

Lab work ☐ Yes ☐ No ____________________

☐ Cervical collar ☐ Ice

Medications:____________________

Other: ____________________

Follow-up instructions: ☐ None____________________

Treatment history:

1. Dr.: ____________________

Specialty:__________ Date first seen: __________

Referred by:__________TX type: __________

TX frequency:__________TX duration: __________

Currently treating? ☐ Yes ☐ No

Any disability? ☐ Yes ☐ No

If yes, describe:____________________

Special tests:____________________

Referred to:____________________

Did TX help? ☐ Yes ☐No

Notes: ____________________

____

2. Dr.: ____________________

Specialty:__________ Date first seen:__________

Referred by:__________TX type:__________

TX frequency:__________TX duration:__________

Currently treating? ☐ Yes ☐ No

Any disability? ☐ Yes ☐ No

If yes, describe:____________________

Special tests:____________________

Referred to:____________________

Did TX help? ☐ Yes ☐No

Notes: ____________________

____

Treatment history: (cont'd)

3. Dr.: ______
Specialty: ______ Date first seen: ______
Referred by: ______ TX type: ______
TX frequency: ______ TX duration: ______
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: ______
Special tests: ______
Referred to: ______
Did TX help? ☐ Yes ☐ No
Notes: ______

4. Dr.: ______
Specialty: ______ Date first seen: ______
Referred by: ______ TX type: ______
TX frequency: ______ TX duration: ______
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: ______
Special tests: ______
Referred to: ______
Did TX help? ☐ Yes ☐ No
Notes: ______

5. Dr.: ______
Specialty: ______ Date first seen: ______
Referred by: ______ TX type: ______
TX frequency: ______ TX duration: ______
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: ______
Special tests: ______
Referred to: ______
Did TX help? ☐ Yes ☐ No
Notes: ______

6. Dr.: ______
Specialty: ______ Date first seen: ______
Referred by: ______ TX type: ______
TX frequency: ______ TX duration: ______
Currently treating? ☐ Yes ☐ No
Any disability? ☐ Yes ☐ No
If yes, describe: ______
Special tests: ______
Referred to: ______
Did TX help? ☐ Yes ☐ No
Notes: ______

Original chief complaints (if injury was not recent):

1. Body part/system: ______
Onset: ______
Provocative: ______
Palliative: ______
Quality: ______
Radiation: ______
Severity (1-4): ______
Temporal: ______

2. Body part/system: ______
Onset: ______
Provocative: ______
Palliative: ______
Quality: ______
Radiation: ______
Severity (1-4): ______
Temporal: ______

3. Body part/system: ______
Onset: ______
Provocative: ______
Palliative: ______
Quality: ______
Radiation: ______
Severity (1-4): ______
Temporal: ______

4. Body part/system: ______
Onset: ______
Provocative: ______
Palliative: ______
Quality: ______
Radiation: ______
Severity (1-4): ______
Temporal: ______

5. Body part/system: ______
Onset: ______
Provocative: ______
Palliative: ______
Quality: ______
Radiation: ______
Severity (1-4): ______
Temporal: ______

Current chief complaints:

1. Body part/system: ______
Onset: ______
Provocative: ______
Palliative: ______
Quality: ______
Radiation: ______
Severity (1-4): ______
Temporal: ______

2. Body part/system: ______
Onset: ______
Provocative: ______
Palliative: ______
Quality: ______
Radiation: ______
Severity (1-4): ______
Temporal: ______

3. Body part/system: ______
Onset: ______
Provocative: ______
Palliative: ______
Quality: ______
Radiation: ______
Severity (1-4): ______
Temporal: ______

4. Body part/system: ______
Onset: ______
Provocative: ______
Palliative: ______
Quality: ______
Radiation: ______
Severity (1-4): ______
Temporal: ______

5. Body part/system: ______
Onset: ______
Provocative: ______
Palliative: ______
Quality: ______
Radiation: ______
Severity (1-4): ______
Temporal: ______

______
______
______
______
______
______

Self assessment as of today: % improved (list for separate areas)

______
______
______

Request records:

- ☐ 1. Request radiographs from: ______
______
- ☐ 2. Request records from: ______
______
- ☐ 3. Request copy of police report.

Referral:

- ☐ For: ______
- ☐ To: ______

Tests to order:

- ☐ Radiographs: ______
- ☐ Tomograms: ______
- ☐ CT: ______
  Area(s): ______
- ☐ MRI: ______
  Area(s): ______
- ☐ MRA: ______
  Area(s): ______
- ☐ Scintigraphy/SPECT: ______
  Area(s): ______
- ☐ Videofluoroscopy: ______
  Area(s): ______
- ☐ EMG/NCV: ______
  Root level/nerve(s): ______
- ☐ SEP: ______
  Root level/nerve(s): ______
- ☐ Other electrodiagnostic test(s): ______
- ☐ Ultrasound: ______
  Area(s): ______

Action taken on this visit:

- ☐ Exam/TX: ______
______
- ☐ Place on disability: ______
- ☐ Work restriction: ______
- ☐ Referral: ______
- ☐ Brace/collar: ______
- ☐ Home traction device: ______
- ☐ NEXERCICER: ______
- ☐ Supplements: ______
- ☐ Other: ______

Patient's Name ______________________ Date __________

Concussion Checklist

Did the patient immediately experience any of the following (circle those appropriate):

Direct Blow to the Head   Loss of Consciousness   Gaps in memory at time of Collision/Fall
Alteration of Consciousness (Dazed/Confused)   Acceleration/Deceleration of Head   Nausea/Dizziness

Any immediate indication of head injury (circle those appropriate):

laceration   area of swelling   scalp abrasion

Has the patient undergone any radiological scans of the head? ____CT ____MRI

Post-Concussive Symptoms	Never	Occasionally	Frequently	Constant
Cognitive Symptoms				
Problems Concentrating, maintaining focus	0	1	2	3
Forgetfulness and memory loss	0	1	2	3
Misplacing personal items	0	1	2	3
Problems finding words/ Expressing thoughts	0	1	2	3
Problems making decisions	0	1	2	3
Trouble staying organized	0	1	2	3
Slowed thinking, feeling dazed	0	1	2	3
Problems alternating attention/ Multi-tasking	0	1	2	3
Becoming overwhelmed easily	0	1	2	3
Physical Symptoms				
Headaches	0	1	2	3
Dizziness	0	1	2	3
Fatigue	0	1	2	3
Slurring words, stuttering	0	1	2	3
Change in sense of hearing, smell, taste	0	1	2	3
Blurred or double vision	0	1	2	3
Tingling in hands, arms, legs, feet	0	1	2	3
Ringing in the ears	0	1	2	3
Increased sensitivity to light or sound	0	1	2	3
"Black-outs" or seizures	0	1	2	3
Emotional Symptoms				
Feelings of sadness, depression	0	1	2	3
Crying spells, weepiness	0	1	2	3
Suicidal thoughts	0	1	2	3
Mood swings/irritability	0	1	2	3
Problems sleeping	0	1	2	3
Low tolerance for frustration	0	1	2	3
Decreased sexual drive	0	1	2	3
Decreased or increased appetite	0	1	2	3
Avoidance of crowds, Decreased interest in socializing	0	1	2	3
Loss of interest in hobbies and activities	0	1	2	3

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MISU OR TOM

Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain	0	1	2	3	4	5	6	7	8	9	10	*Unbearable pain*

Name ______________________________ **Date** ______________

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – Pain Intensity
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping
0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

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

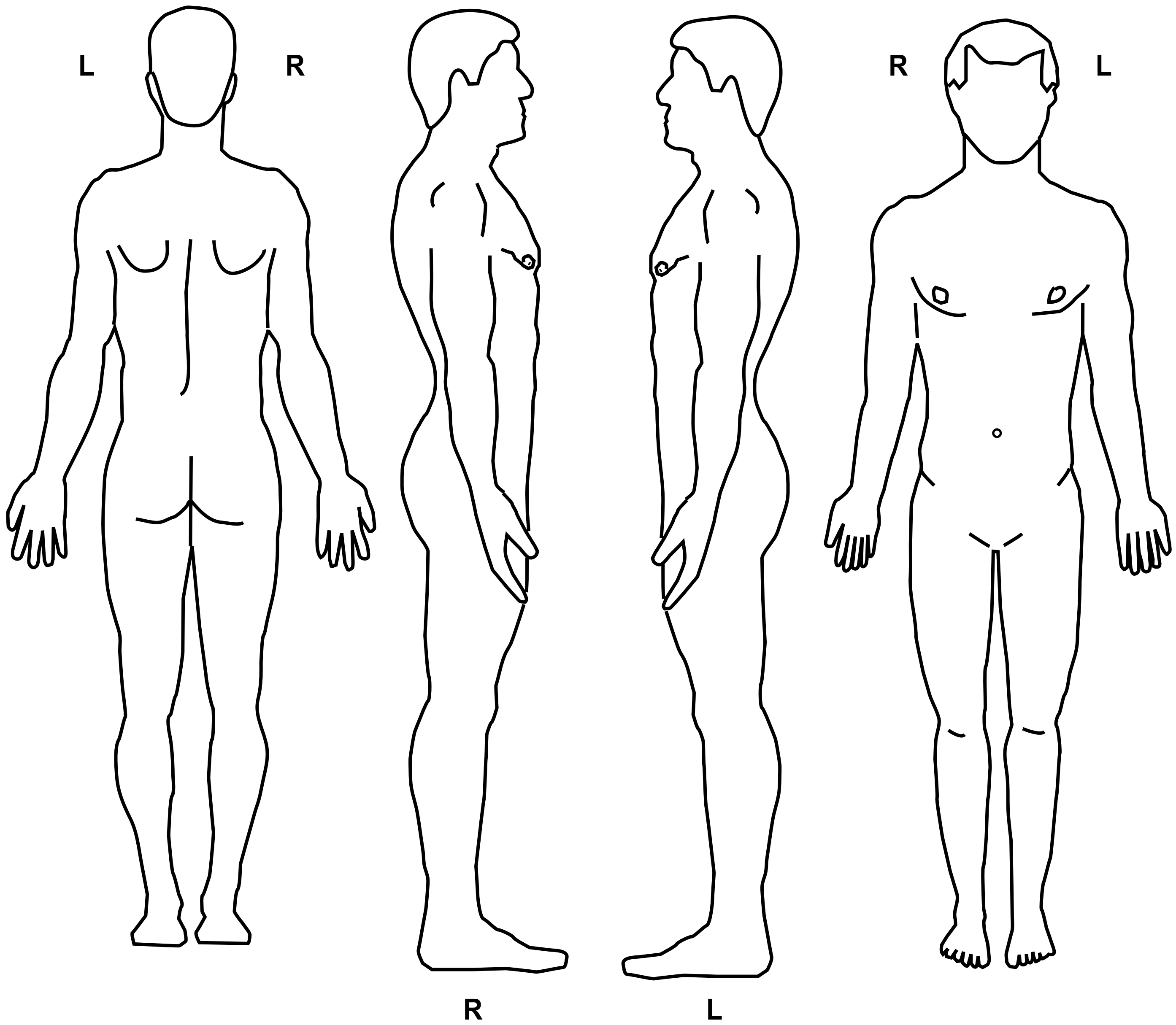
Section 9 – Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL ______________

PAIN DRAWING

Name ____________________ Date ____________



Mark as follows:
A - Ache B - Burning N - Numbness P - Pins & Needles
S - Stabbing O - Other - Describe ____________________

Table 8-14.
Long-Term Outcome of Cervical Spine Injuries Reported in the Literature

Author(s)	Year	N	Type of Crash	Follow-up	% Chronic
Gotten (37)	1956	100	Mixed	>1 yr	46
Macnab (4)	1964	266	Mixed	>2 yr	45-83[1]
Hohl (116)	1974	146	Mixed	>5 yr	43
Ellertsson et al. (22)	1978	100	Rear end	1.5 yr	12[2]
Norris and Watt (299)	1983	61	Rear end	2 yr	44-90[3]
Ebbs (526)	1986	137	Mixed	1 yr	26
Deans et al. (54)	1987	137	Mixed	1 yr	26
Miles et al. (300)	1988	73	Mixed	2 yr	29
Maimaris et al. (311)	1988	102	Mixed	2 yr	34
McKinney (530)	1989	167	Mixed	2 yr	23-46[4]
Pearce (259)	1989	100	Mixed	1 yr	15
Hodgson and Grundy (528)	1989	40	Mixed	10-15 yr	14-62
Hildingsson and Toolanen (216)	1990	93	Mixed	2 yr	58
Olsson et al. (248)	1990	33	Rear end	1 yr	41[5]
Pennie and Agambar (531)	1990	135	Mixed	0.5 yr	13
Gargan and Bannister (240)	1990	43	Mixed	10.8 yr	88
Watkinson et al. (117)	1991	43	Rear end	10.8 yr	86
Kischka et al. (532)	1991	52	Mixed	>2 yr	44-61[6]
Rananov et al. (291)	1991	178	Mixed	0.5 yr	27
Ettlin et al. (217)	1992	21	Mixed	2 yr	35;41;29[7]
Parmar and Raymakers (298)	1993	100	Rear end	8 yr	55
Robinson and Cassar-Pellucino (529)	1993	21	?	10-19 yr	86
Hildingsson et al. (412)	1993	38	Mixed	>1 yr	45-34[8]
Radanov et al. (237)	1993	97	Mixed	0.5 yr	27[9]
Radanov et al. (296)	1993	98	Mixed	0.5 yr	32[9]
Ono and Kanno (252)	1993	?	Mixed	?	15-20[10]
Gargan and Bannister (533)	1994	50	Rear end	2 yr	62[11]
Ryan et al. (220)	1994	429	Mixed	0.5 yr	66
Jónsson et al. (222)	1994	50	Mixed	5 yr	32
Radanov et al. (297)	1994	117	Mixed	1 yr	24
Di Stefano et al. (534)	1995	117	Mixed	2 yr	18[9]
Spitzer et al. (225)	1995	3014	Mixed	6 yr	?[12]
Borchgrevink et al. (236)	1996	345	Rear end	>2.5 yr	58
Mayou and Bryant (263)	1996	57	Mixed	1 yr	49
Squires et al. (239)	1996	40	Rear end	15.5 yr	70
Pettersson et al. (238)	1997	39	Mixed	2 yr	15/44[13]
Karlsborg et al. (535)	1997	39	Mixed	0.6 yr	71
Gargan et al. (235)	1997	52	Rear end	2 yr	64
Voyvodic et al. (536)	1997	29	?	0.5 yr	62
Borchgrevink et al. (276)	1997	88	Mixed	1 yr	28[14]
Borchgrevink et al. (537)	1998	201	Mixed	0.5 yr	41-66[15]
Krafft et al. (538)	1998	23	Rear end	>0.5 yr	4-26[16]
Olivegren et al. (539)	1999	22	Mixed	2 yr	100

[1]Actual percentage between 45 and 83.
[2]Very little data provided.
[3]Three groups; ranged from 44 to 90% still symptomatic.
[4]Trial of mobilization therapy only.
[5]Percentage based on 29 patients who were injured.
[6]Neck pain = 44; headaches = 61.
[7]Neck pain = 35; headaches = 41; cognitive problems = 29.
[8]All symptoms = 45; visual symptoms = 34.
[9]Cognitive symptoms.
[10]Statistics from Auto Insurance Rating Association of Japan. Reported as "prolonged symptoms."
[11]48 at one year; 62 at two years.
[12]97% "recovered" at one year; "recovered" defined only as returned to work. No data on symptoms given.
[13]15% had daily symptoms; 44% symptomatic at 6 months.
[14]Of rear impacts, 48% symptomatic at 6 months.
[15]Some symptoms of HA = 41-59 across groups; neck pain = 52-66 across groups.
[16]Incomplete follow-up: 4 to 26% possible.