

# 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: \_\_\_\_\_

Unemployed

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 \_\_\_\_°

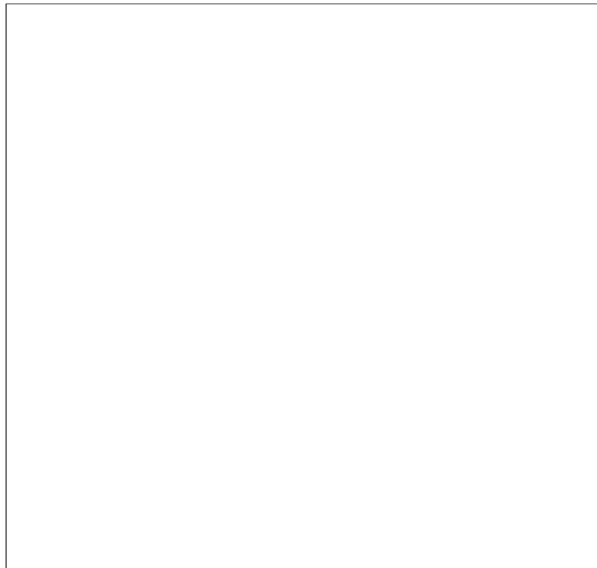
Injury history. General: (cont'd)

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: \_\_\_\_\_