N. Birrell Smith, M.D.
Orthopaedic Surgery

Accident/Injury Form

Body Part for this Visit: Right or Left _____
(circle one & indicate part)

Describe your current problem:

Is this a chronic condition? yes no

How did condition occur? _____

_____

Where were you? _____

When? _____

Previous Tests and Treatments:

□ Physical Therapy	□ Made it better	□ Made it worse	□ No effect
□ Anti-inflammatory	□ Made it better	□ Made it worse	□ No effect
□ Narcotic Meds	□ Made it better	□ Made it worse	□ No effect
□ Chiropractor	□ Made it better	□ Made it worse	□ No effect
□ Steroid injection	□ Made it better	□ Made it worse	□ No effect
□ X-ray			
□ MRI			
□ Other			
□ _____	□ Made it better	□ Made it worse	□ No effect

1. Do you think your problem is related to work? (if Yes, answer #2) YES or NO
2. Have you filed a workers' comp claim with your employer? YES or NO

   If YES: A. Have you notified our office? YES or NO

   a. If NO, ***immediately*** notify our office at 434-0876.

   b. If YES, bring a copy of your claim form to your appointment.

   B. Has your claim been denied or put in delay? YES or NO

   a. If YES, bring a copy of your denial/delay letter to your appointment.

I CERTIFY THE ABOVE STATEMENTS TO BE TRUE TO THE BEST OF MY KNOWLEDGE.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Relationship to Patient

→

Patient Name _____

Please Mark <u>All</u> that Apply to your Current Problem

This condition began:

_____ hours, days, weeks, months, years ago

The quality/character/nature is:

Aching	shooting
burning	stabbing
constant	swelling
dull	throbbing
excruciating	tingling
gnawing	worsening
improving	numbness
intermittent	cold sensation
sharp	tender to touch

Onset was:

Onset was:

Sudden
Gradual
Recurrent
Unknown
After _____
(Activity or description)

The severity/harshness is:

_____ on a scale of 0 to 10, 10 is worse

improving	unbearable
mild	unchanged
moderate	worsening
resolved	recurrent
severe	

Occupation? _____

Specific activities involved? (Cook: chopping, standing; Construction: lifting, climbing stairs/ladder)

_____

_____

How do the following effect your condition?

bending	□ Made it better	□ Made it worse	□ No effect
cold weather	□ Made it better	□ Made it worse	□ No effect
elevation	□ Made it better	□ Made it worse	□ No effect
exercise	□ Made it better	□ Made it worse	□ No effect
gripping	□ Made it better	□ Made it worse	□ No effect
heat	□ Made it better	□ Made it worse	□ No effect
ice	□ Made it better	□ Made it worse	□ No effect
jumping	□ Made it better	□ Made it worse	□ No effect
kneeling	□ Made it better	□ Made it worse	□ No effect
lifting	□ Made it better	□ Made it worse	□ No effect
lying down	□ Made it better	□ Made it worse	□ No effect
medications	□ Made it better	□ Made it worse	□ No effect
overhead activities	□ Made it better	□ Made it worse	□ No effect
rest	□ Made it better	□ Made it worse	□ No effect
running	□ Made it better	□ Made it worse	□ No effect
shoe gear	□ Made it better	□ Made it worse	□ No effect
sitting	□ Made it better	□ Made it worse	□ No effect
squatting	□ Made it better	□ Made it worse	□ No effect
stair climbing	□ Made it better	□ Made it worse	□ No effect
standing	□ Made it better	□ Made it worse	□ No effect
walking	□ Made it better	□ Made it worse	□ No effect