

TRAUMA

Fill out this page for *any* accident, fall, injury or traumatic event in the patient's past history other than a motor vehicle accident.

Patient Name:

Describe the accident or event:

Date or age:

Time:

Location:

Description of injuries:

Object that impacted body:

Floor/ground

Wall/door

Other:

Moving object

Stationary object

Both moving

Hard object

Medium

Soft object

Approximate speed at the time of impact:

1 mph

2 mph

3 mph

Other:

Location of trauma:

No observable tissue injury

Top head

Forehead

Back head

Jaw

Jaw joint

Behind ear

Ear

Cheek

Chin

Nose

Lips

Teeth

Tongue

Neck

Eyes

Other:

Other body trauma:

Arm

Leg

Neck

Shoulder

Back

Hips

Ribs

Internal Organs

Other:

Symptoms first noted:

Immediately

Same day

Next day

One week

One month

Six months

One year

Describe symptoms:

Symptoms first treated:

Immediately

Same day

Next day

One week

One month

Six months

One year

First medical care received at:

by attending ER doctor

private physician

Other:

Treatment provided at time of injury:

Treatment To Date

Dates	Caregiver	Treatment	Results

Residual problems:

Maximal Medical Improvement (MMI):

Yes

No