ANI ORTHOPAEDIC GROUP

Orthopaedic & Spine Institute of New Jersey

For all MVA or Workman's Comp claims please fill out the below information:

Patient Name:_____

Date of accident/injury:_____ Ins Company: _____ Claim #:_____

Are you still working?
If Yes Modified Duty or Full Duty (circle one)

If No Last day on job:_____

Details of the injury: Check all that apply:

MVA: ❑ Driver ❑ Front Seat Passenger ❑ Rear Seat Passenger
❑ Restrained ❑ Unrestrained Impact to your car was:❑ Head-on ❑Side ❑Rear

W/C: ❑Fall ❑ injured by machine ❑ other please describe:
_____

Body parts injured:

❑ neck ❑ back ❑shoulder ❑ Knee ❑other: _____

What activities make the pain worse? (please describe)
_____
_____

Were you hospitalized overnight?
❑ Yes ❑ No

What reduces the pain? ❑ Lying down ❑ Sitting ❑ Standing ❑ Walking ❑ Ice
❑ Heat ❑ Pain pills ❑Anti-inflammatory pills ❑ Muscle Relaxant pills ❑Injections for pain ❑Physical therapy
❑ Other

Have you had this pain before?
❑No ❑Yes
❑When?_____
_____

Name of physicians who have treated this problem:
_____
_____

Have you had any of these diagnostic studies? If yes, what body part and when was this done?
Diagnostic X-rays: Y N CTScan: Y N MRI: Y N Electromyogram (EMG): Y N

What medications and/or supplements are you currently taking for this condition?
_____
_____