Injury Questionnaire

Name **Date**

Check off the area which experienced injury. This could include a blow to the head, punch in the nose, twisted ankle, stubbed toe, broken bone, major sore throat, lung infection, injections, surgery, low back strain, punch in stomach, fall on buttocks, fall on knees, muscle tear, lumbar puncture, cut cornea (eyeball), sports injury, groin injury, whiplash--neck and seatbelt trauma, etc.

Make specific notes regarding injured area (i.e. left or right).

Body Part	Scar	Trauma/Injury	Infection
Head Front Top Sides Back			
Ear (inside)			
Eye Area			
Face			
Teeth			
Nose			
Throat			
Chest (Ribs), Breast Bone			
Rib			
Upper back			
Shoulder			
Arm, elbow, wrist, fingers			
Abdomen, Stomach			
Low Back			
Hip			
Groin Area			
Tail Bone			
Thigh			
Knee			
Calf (back of lower leg)			
Shin (front lower leg)			
Ankle, heal, toes			
Other			
Other			
Other			
Other			
Other			