

Work Accident History

(Please Print)

Patient Information

Dr./Mr./Mrs./Ms./Miss (circle one)

Acct# _____

Marital Status (circle one) M S W D

Last Name First Name Middle Initial Nick Name

Address City State Zip Code

Mobile phone# _____ Home phone# _____

Email address _____

Social Security No _____ Date of Birth _____ Sex [] M [] F

Occupation (specific job title) _____

Person to contact in an emergency _____ Phone# _____

Employer Information

Company Name Supervisor Name Work Phone#

Address City State Zip Code

Nature of business (eg., food manufacturing, building construction, retailer of women's clothes)

Insurance Information

If you have any insurance information please give it to the staff person assisting you.

Symptoms

1. Date of accident/injury: _____ [] Gradual [] Sudden [] Progressive

2. Address/location where you were injured:

No. and Street City County

3. Time of day when accident occurred: _____ am/pm Date last worked: _____

4. Did you report this to your employer? [] Y [] N If so, to whom? _____

5. Did you go to the hospital or another's doctor's office after the accident? [] Y [] N

If so, where: _____ Were X-Ray's taken? [] Y [] N

What type of treatment was administered? _____

Was a diagnosis made? [] Y [] N If so, what was it? _____

6. Describe how the accident/injury happened: _____

7. What is your **number-one** problem or the **one area** of greatest pain? _____

8. Have you ever experienced this problem before [] Y [] N When? _____

9. Please rate the level of this pain on the following scale: 0 is no pain, 10 is severe pain or the worst pain you have ever felt. If your pain varies from day to day please circle two numbers to indicate a range of your pain.

0 1 2 3 4 5 6 7 8 9 10

10. How often do you experience the pain?

___ 1-2 hours per day ___ About half of the day
___ Most of the day ___ The pain never goes away

11. How does the pain effect your daily activities?

___ It does not effect my daily work or home activities.
___ I have had to change how I do my work or home activities. Explain: _____
___ I cannot do the following due to my present problem: _____
___ I am unable to do nearly everything I am accustomed to doing.

12. What **increases** your pain? _____

13. What **decreases** your pain? _____

14. List any other complaints currently bothering you and rate your pain level for each.

a. _____	0 1 2 3 4 5 6 7 8 9 10
b. _____	0 1 2 3 4 5 6 7 8 9 10
c. _____	0 1 2 3 4 5 6 7 8 9 10
d. _____	0 1 2 3 4 5 6 7 8 9 10

15. Do you feel you could perform your usual job right now? [] Y [] N

16. Describe your routine job duties: _____

17. If you are working, how has your current condition affected your normal duties? _____

18. Is there any activity or duty you are unable to perform? _____

19. How often does your job require you to do the following:

- ___ Lifting (___ lbs)
- ___ Sitting (___ hrs/day)
- ___ Standing (___ hrs/day)
- ___ Computer (___ hrs/day)
- ___ Telephone (___ hrs/day)
- ___ Driving (___ hrs/day)
- ___ Push/pull ___ Once in a while ___ Often ___ Frequently ___ Almost all the time
- ___ Reach overhead ___ Once in a while ___ Often ___ Frequently ___ Almost all the time
- ___ Grasping ___ Once in a while ___ Often ___ Frequently ___ Almost all the time
- ___ Twisting/bending ___ Once in a while ___ Often ___ Frequently ___ Almost all the time
- ___ Squatting/kneel ___ Once in a while ___ Often ___ Frequently ___ Almost all the time
- ___ Walking ___ Once in a while ___ Often ___ Frequently ___ Almost all the time
- ___ Climbing/ladders ___ Once in a while ___ Often ___ Frequently ___ Almost all the time
- ___ Other Please explain: _____

20. Have you ever been injured at work prior to this accident/injury? [] Y [] N When?

Please explain _____

21. Have you ever been involved in an automobile accident? [] Y [] N When? _____

Were you injured? [] Y [] N Please explain _____

22. List all medication you are currently taking (prescribed and over the counter) _____

23. List all surgeries you have had (with date) _____

24. Please provide your medical doctors name _____

25. Please provide any previous chiropractors you have treated with _____

If you have experienced any of the following conditions in the past mark with a "P" on the line provided. If you are currently experiencing any of the following conditions please mark a "C" on the line provided. (Check all that apply)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> heart attack | <input type="checkbox"/> stroke | <input type="checkbox"/> arthritis | <input type="checkbox"/> gall bladder trouble |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> glaucoma | <input type="checkbox"/> fainting spells | <input type="checkbox"/> kidney stones |
| <input type="checkbox"/> bloody stools | <input type="checkbox"/> cancer | <input type="checkbox"/> asthma | <input type="checkbox"/> difficulty with urination |
| <input type="checkbox"/> prostate trouble | <input type="checkbox"/> anemia | <input type="checkbox"/> AIDS | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> diverticulitis | <input type="checkbox"/> dizziness | <input type="checkbox"/> chest pain | <input type="checkbox"/> menstrual cramping |
| <input type="checkbox"/> loss of memory | <input type="checkbox"/> constipation | <input type="checkbox"/> diarrhea | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> general fatigue | <input type="checkbox"/> nausea | <input type="checkbox"/> muscle cramping | <input type="checkbox"/> sudden weight loss |
| <input type="checkbox"/> ears ringing | <input type="checkbox"/> headache | <input type="checkbox"/> soreness in joints | <input type="checkbox"/> loss of hearing |
| <input type="checkbox"/> migraine | <input type="checkbox"/> epilepsy | <input type="checkbox"/> gout | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> syphilis | <input type="checkbox"/> knee/hip replacement | <input type="checkbox"/> sprained ankle [] R [] L | |
| <input type="checkbox"/> difficulty with bowel movements | <input type="checkbox"/> broken bones(specify)_____ | | |

General Activities (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> sleep on waterbed | <input type="checkbox"/> read in bed | <input type="checkbox"/> fall asleep in recliner/on couch |
| <input type="checkbox"/> sleep on stomach | <input type="checkbox"/> needlepoint/knitting | <input type="checkbox"/> use two or more pillows to sleep |
| <input type="checkbox"/> sewing | <input type="checkbox"/> lift weights.wt. mach. | <input type="checkbox"/> play video games(___hrs per week) |
| <input type="checkbox"/> jog____x/wk | <input type="checkbox"/> swim | <input type="checkbox"/> computer use (___hrs per week) |
| <input type="checkbox"/> exercise____x/wk | <input type="checkbox"/> use treadmill | <input type="checkbox"/> watch Television (___hrs per week) |

Please add anything else you would like the doctor to know: _____

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my worker's compensation claim may be denied. If my claim is denied, I agree to be responsible for payment of all services rendered on my behalf.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Patient's Signature _____ Date _____

Doctor's Comments: _____

Doctor's Signature _____ Date _____