Work Accident History

(Please Print)

Patient Information **Acct#** _____

Dr./Mr./Mrs./Ms./Miss *(circle one)* Marital status *(circle one)* M S W D

_____

Last Name First Name Middle Initial Nick Name

_____

Address City State Zip Code

Home phone#_____ Pager#_____ Cell 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.

Accident/Injury History

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 occured:_____ am/pm Date last worked:_____
4. Did you report this to you employer? [ ] Y [ ] N If so, to whom?_____
5. Did you go to the hospital or another doctor's office after the accident? [ ] Y [ ] N
   If so, where:_____ Were X-rays 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/kneeling (___ 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 Explain:_____

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

Explain_____

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

Were you injured? [ ] Y [ ] N Explain_____

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

_____

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

_____

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

_____

If you have experienced any of the following conditions in the past mark 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)*

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

General Activities *(check all that apply)*

___ sleep on waterbed	___ read in bed	___ fall asleep in recliner/on couch
___ sleep on stomach	___ needlepoint/knitting	___ use two or more pillows to sleep with
___ sewing	___ lift weights/wt. mach.	___ play video games (____ hrs per day)
___ exercise _____x/wk	___ jog _____x/wk	___ computer use (____ hrs per day)
___ swim	___ use healthrider	___ watch television (____ hrs per day)

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 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_____

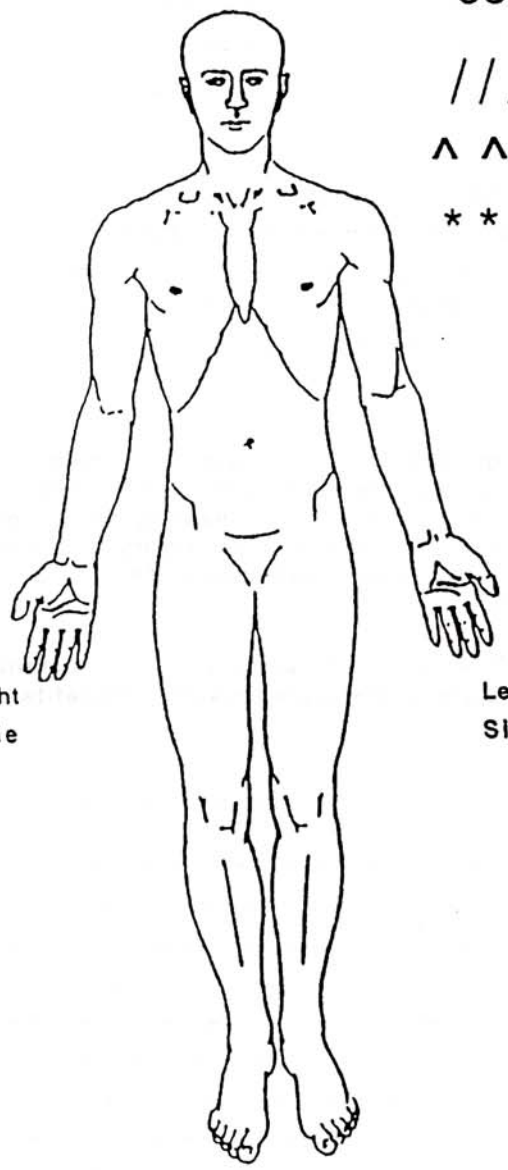
Doctor's Comments:_____

Body Diagram

Acct# _____

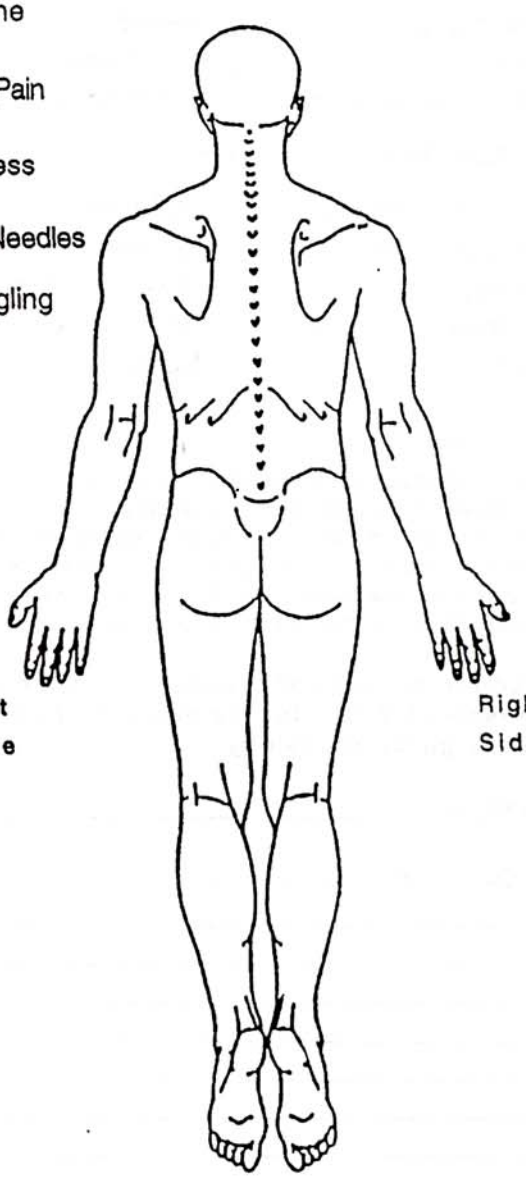
Last Name _____ First Name _____

XXX	Sharp Pain
OOO	Dull Ache
///	Burning Pain
^ ^ ^	Numbness
* * *	Pins & Needles or Tingling



Right Side

Left Side



Left Side

Right Side

Patient Signature _____ Date _____

(Signature of parent if the patient is a minor)