

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

**Fill Out If You Have Been in a Job Related Injury**

Date and time of accident: \_\_\_\_\_  a.m.  p.m.

Was your accident directly related to your work?  Yes  No

Briefly describe the events that occurred just before and during your accident: \_\_\_\_\_

---

Give the address where the accident occurred: (if other than employer's address) \_\_\_\_\_

Was anyone else present during your accident?  Yes  No

Did you report your accident to your employer?  Yes  No

What recommendations did your employer make just after your accident? \_\_\_\_\_

Has this type of accident happened to you before?  Yes  No

To the best of your knowledge, has this accident occurred in your workplace before?  Yes  No

In general:

Is your job physically stressful?  Yes  No

Is your job mentally stressful?  Yes  No

Is your workplace noisy?  Yes  No

Have you changed jobs in the last year?  Yes  No

**After Injury**

Did accident render you unconscious?  Yes  No

If yes, for how long? \_\_\_\_\_

Please describe how you felt immediately after the accident:

---

Have you gone to a hospital or seen any other Doctor?  Yes  No

When did you go?  Just after accident  The next day  2 days plus

How did you get there?  Ambulance  Private transportation

Name of hospital and/ or attending doctor:

---

Was he/she a:  D.C.  M.D  D.O  D.D.S

Describe any treatment you received: \_\_\_\_\_

Were X-Rays taken?  Yes  No

Was medication prescribed?  Yes  No

Have you been able to work since this injury?  Yes  No

Are your work activities restricted as a result of this injury?  Yes  No

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Indicate the symptoms that are a result of this accident:

- Dizziness       Difficulty Sleeping       Jaw problems       Nausea
- Memory loss       Irritability       Arms/ shoulder pain       Back pain
- Headache(s)       Fatigue       Numb hands/       Lower back pain
- Blurred vision       Tension      fingers       Back stiffness
- Buzzing in ear       Neck pain       Chest pain       Leg pain
- Ears ringing       Neck stiff       Shortness of breath       Numb feet/ toes
- Stomach upset

Other \_\_\_\_\_

Is your condition getting worse?  Yes  No  Constant  Comes and goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on stomach.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lovemaking.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you retained an attorney:  Yes  No

If yes, whom? \_\_\_\_\_

His/ Her phone #: \_\_\_\_\_

**Recovery**

How many hours are in your normal workday? \_\_\_\_\_

Please indicate on your daily job duties and any activities, which you are occasionally asked to perform.

<input type="checkbox"/> Standing	<input type="checkbox"/> Driving	<input type="checkbox"/> Operating equipment
<input type="checkbox"/> Sitting	<input type="checkbox"/> Twisting	<input type="checkbox"/> Work with arms above head
<input type="checkbox"/> Walking	<input type="checkbox"/> Crawling	<input type="checkbox"/> Typing
<input type="checkbox"/> Lifting	<input type="checkbox"/> Bending	<input type="checkbox"/> Stooping

 Other \_\_\_\_\_

What positions can you work in with minimum physical effort and for how long?

\_\_\_\_\_  
\_\_\_\_\_  N/APrior to the injury were you capable of working on an equal basis with others your age?  Yes  No  N/ADo you work with others who can help you with any heavy lifting?  Yes  No  N/AWhile in recovery, is there any light duty work you could request?  Yes  No  N/A

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

 Adult patient  Parent or Guardian  Spouse