



Work Accident Form
(Please Print)

Name _____ Date _____

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: _____ Mobile Phone: _____

Email address: _____

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

Occupation (specific job title) _____

Person to contact in case of 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 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 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. If your pain varies from day to day please circle two numbers to indicate that range.)**

0 1 2 3 4 5 6 7 8 9 10



10. How often do you experience this 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 affect your daily activities?

- It does not affect my daily work or home activities.
 I have had to change how I do my work or home activities. Please 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 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 before? [] Y [] N When? _____

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

22. List all surgeries you have had (including the date): _____

23. List all medications 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, mark a "C" on the line provided.

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

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 2+ pillows to sleep with |
| <input type="checkbox"/> sewing | <input type="checkbox"/> lift weights/wt. mach. | <input type="checkbox"/> play video games (___ hrs per day) |
| <input type="checkbox"/> exercise _____x/wk | <input type="checkbox"/> jog _____x/wk | <input type="checkbox"/> computer use (___ hrs per day) |
| <input type="checkbox"/> swim | <input type="checkbox"/> use healthrider | <input type="checkbox"/> 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: _____

