



# Work Accident History

*Please Print*

## Patient Information

Acct# \_\_\_\_\_

We want to get to know you and appreciate you filling in our forms!

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex:  M  F Marital Status:  M  S  D  W

Email Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Females; are you pregnant?  Y  N Date of Last Menstrual Cycle: \_\_\_\_\_

Have you ever received chiropractic care in the past?  Y  N Last Date Treated: \_\_\_\_\_

## Employer

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Employer Phone \_\_\_\_\_

## Spouse

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Children and Ages: \_\_\_\_\_

## Emergency Contact

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Contact phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I authorized the release of any medical information necessary to process this claim and authorize payment of services to this office. I understand any amount paid directly to the office will be credited to my account. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. I will make payment for my portion of charges at each visit unless other arrangements are made.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



(signature of parent or guardian if the patient is a minor)



**Accident/Injury History**

1. Date of Accident/Injury: \_\_\_\_\_  Gradual  Sudden  Progressive
2. Address/Location where you were injured? \_\_\_\_\_  

No. and Street	City	County
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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 did you receive? \_\_\_\_\_  
 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 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 using the same scale as above.
 

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

- a. If yes, when? \_\_\_\_\_
- b. Please explain: \_\_\_\_\_

21. Have you ever been involved in an automobile accident before?  Y  N

- a. If yes, when? \_\_\_\_\_
- b. Were you injured?  Y  N    Please explain: \_\_\_\_\_

22. List all surgeries you have had (with date) \_\_\_\_\_  
\_\_\_\_\_

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

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)

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

General Activities (check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> sleep on waterbed                     | <input type="checkbox"/> play video games (___ hrs per day) |
| <input type="checkbox"/> read in bed                           | <input type="checkbox"/> exercise ___ x/wk.                 |
| <input type="checkbox"/> fall asleep in recliner / on couch    | <input type="checkbox"/> jog ___x/wk.                       |
| <input type="checkbox"/> sleep on stomach                      | <input type="checkbox"/> computer use (___ hrs per day)     |
| <input type="checkbox"/> needlepoint/ knitting                 | <input type="checkbox"/> swim                               |
| <input type="checkbox"/> use two or more pillows to sleep with | <input type="checkbox"/> use treadmill / elliptical machine |
| <input type="checkbox"/> sewing                                | <input type="checkbox"/> watch television (___ hrs per day) |
| <input type="checkbox"/> lift weights / weight machine         |   |

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 or my child 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 insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

*(signature of parent if the patient is a minor)*

Doctor's Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_