Complete Chiropractic

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Suite 8
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(610) 841-2204

Worker's Compensation History

Name: _____ Date of Accident: _____

1. Name of employer at the time of accident: _____
2. Length of time worked there prior to accident: _____
3. Type of work being done at time injury: _____
   _____
4. In your own words, please describe accident: _____
   _____
   _____
   _____
5. Have you been treated by another doctor for this accident? _____Yes _____No
   If yes, please list doctor's name and address: _____
   _____
   What type of treatment did you receive? _____
   How long were you treated by this doctor? _____
6. Are you: ☐ improved ☐ unchanged ☐ getting worse
7. What types of medicines are you taking? _____
   _____
   Do these medicines help? ☐ Yes ☐ No ☐ Don't know
8. Have you had physical therapy? ( )Yes ( ) No If yes, how often?
   ☐ Daily ☐ Every other day ☐ Several times a week ☐ Weekly
   ☐ Every other week ☐ Monthly ☐ Other _____
9. Prior to this accident, have you ever had any of the physical complaints similar to what you have now? ☐ Yes ☐ No ☐ Don't know
   If yes, describe: _____
   _____
   _____
   Were these similar complaints the results of previous accident(s)?
   ☐ Yes ☐ No ☐ Not Applicable
   Please provide details of accident(s): _____
   _____
   _____
10. Have you had any other serious accidents which required medical care?
    ☐ Yes ☐ No
    Describe: _____
11. Have you had any serious illnesses that required hospitalization?
    ☐ Yes ☐ No
    Describe: _____
    _____
    _____
12. Have you had any surgeries? ☐ Yes ☐ No
    If yes, list type of surgery and date:_____
    _____
    _____

13. Have you had any nervous or mental illnesses? ☐ Yes ☐ No
    Have you had psychiatric care? ☐ Yes ☐ No
14. Have you received a medical discharge from the Armed Forces?
    ☐ Yes ☐ No
15. Have you returned to work since this accident? ☐ Yes ☐ No
    If you have returned to work since your accident,
    please fill out the information below:

Current Medical Complaints

Back Pain:

1. Currently, I have pain in my: .. ☐ low back ☐ mid back ☐ upper back
2. My pain began: ..... ☐ gradually ☐ suddenly
3. I have pain:..... ☐ sometimes ☐ all of the time

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY RUGULAR DUTY	FULL TIME PART TIME

4. My pain goes into my: ..... ☐ right leg ☐ left leg ☐ both ☐ neither
5. I have tingling and/or numbness in my:
   ..... ☐ right leg ☐ left leg ☐ both ☐ neither
6. My pain is worse when I:
   cough or sneeze..... ☐ Yes ☐ No
   sit..... ☐ Yes ☐ No
   bend..... ☐ Yes ☐ No
   walk..... ☐ Yes ☐ No
   lift..... ☐ Yes ☐ No
   push..... ☐ Yes ☐ No
   pull ..... ☐ Yes ☐ No
7. My back pain is worse with sexual activity.... ☐ Yes ☐ No
8. My pain wakes me up during the night..... ☐ Yes ☐ No
9. Changes in the weather affect my pain ..... ☐ Yes ☐ No

Neck Pain: Complete only if applicable

1. My neck pain began:..... ☐ gradually ☐ suddenly
2. I have pain:..... ☐ sometimes ☐ all of the time
3. My pain goes into my: ..... ☐ right arm ☐ left arm ☐ both
4. I have tingling and/or numbness in my:
   ..... ☐ right arm ☐ left arm ☐ both
5. My pain is worse when I:
   cough or sneeze..... ☐ Yes ☐ No
   bend forward ..... ☐ Yes ☐ No
   lift..... ☐ Yes ☐ No
   push..... ☐ Yes ☐ No
   pull ..... ☐ Yes ☐ No
   turn my head ..... ☐ Yes ☐ No

Neck Pain (continued):

6. My pain wakes me up during the night ..... ☐ Yes ☐ No
7. Changes in the weather affect my pain ..... ☐ Yes ☐ No
8. I have neck stiffness..... ☐ Yes ☐ No
9. I have headaches ..... ☐ Yes ☐ No
10. If I do get headaches, they occur: .... ☐ sometimes ☐ all of the time

Other Pain:
Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition. _____

_____

_____

_____

Job Description:
(In terms of an 8 hour workday, "occasionally" means 33%, "frequently" means 34% to 66% and "continuously" means 67% to 100% of the day.)

1. In a typical 8-hour workday, I: (Circle # of hours / activity)

Sit:	1	2	3	4	5	6	7	8 hours
Stand:	1	2	3	4	5	6	7	8 hours
Walk:	1	2	3	4	5	6	7	8 hours

2. On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY		FREQUENTLY	CONTINUOUSLY
Bend/stoop	☐	☐	☐	☐	☐
Squat	☐	☐	☐	☐	☐
Crawl	☐	☐	☐	☐	☐
Climb	☐	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐	☐
Crouch	☐	☐	☐	☐	☐
Kneel	☐	☐	☐	☐	☐
Balancing	☐	☐	☐	☐	☐
Pushing/ Pulling	☐	☐	☐	☐	☐

3. On the job, I lift:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Up to 10 pounds	☐	☐	☐	☐
11 to 24 pounds	☐	☐	☐	☐
25 to 34 pounds	☐	☐	☐	☐
35 to 50 pounds	☐	☐	☐	☐
51 to 74 pounds	☐	☐	☐	☐
75 to 100 pounds	☐	☐	☐	☐

4. Do you have to bend over while doing any lifting? ☐ Yes ☐ No

5. Are your feet used for repetitive movements, such as in operating foot controls?
   ☐ Yes ☐ No

6. Do you use your hands for repetitive actions, such as:

	SIMPLE GRASPING		FIRM GRASPING		FINE MANIPULATION	
Right Hand	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Left Hand	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

7. Are you required to work on unprotected heights? ☐ Yes ☐ No
Describe: _____
_____
_____

8. Are you required to be around moving machinery? ☐ Yes ☐ No
Describe: _____
_____

9. Are you exposed to marked change in temperature and humidity? ☐ Yes ☐ No
Describe: _____
_____
_____

10. Are you required to drive automotive equipment? ☐ Yes ☐ No
Describe: _____
_____
_____

11. Are you exposed to dust, fumes and/or gasses? ☐ Yes ☐ No
Describe: _____
_____
_____

12. Please list any additional comments: _____
_____
_____

I have read and completed all answers to the above questions to the best of my knowledge. I am aware that answering yes to any of the above questions may require me to undergo further testing prior to starting any appropriate care. I hereby give my full consent to undergo a care program designed for me if determined to be clinically medically necessary by my doctor. I will notify them of any changes in my health status during the duration of the program. It is also my duty to daily inform the doctor or assistant of any possible complication prior to the initiation of my daily treatment.

Your signature _____ Date _____

Physician signature _____ Date _____