# Highland Chiropractic Family Care

## WORKERS COMPENSATION INFORMATION

Please print clearly and fill in completely

**Patient Name:**_____**Date:**_____/_____/_____

**Date of accident:**____/_____/____ **Age:**_____ ☐ **Male** ☐ **Female** **D.O.B:**___/___/_____.

**Status:** ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

**Address:**_____

STREET CITY ZIP

**Tell #: (H)**_____(W)_____(Cell)_____

**Spouses name:**_____**Number of children:**_____

**Your Employer:**_____**Occupation:**_____

**Employers Address:**_____

**E-mail Address:**_____

**Primary Care Physician:** _____**Tel:**_____

**Most recent visit:** _____/_____/_____

**Describe physical &/or administrative duties** ☐ **lifting** ☐ **bending** ☐ **twisting** ☐ **standing** ☐ **prolonged sitting**

**Have you stopped working since the accident:** yes no **If no, are you working in distress:** yes no **If yes, is it because of finances:** yes no

**What else have you been unable to do since the accident:** ☐ **Exercise** ☐ **Play sports** ☐ **Household chores** ☐ **Take care of children** ☐ **Play with children**

**What other activities have you been unable to do because of the accident:**_____

_____

**Do you smoke cigarettes:** yes no **if yes, how many:**_____ **Do you drink alcohol:** yes no **if yes, how often and how much:**_____

**Past medical history: Any other motor vehicle accidents:** yes no

**If yes, what were the dates and what were the injuries:**_____

_____

**Have you had any previous injuries (work – sports – home chores) to your neck, middle or lower back or any extremities:** yes no **If yes, please describe injury; its date; and where it occurred:**_____

_____

_____

# Highland Chiropractic Family Care



**Have you ever been treated for a medical condition:** yes no **If yes, when and for what condition and did it involve surgery:**_____

_____

_____

**Are you currently taking any medication:** yes no **If yes, what medication and for what condition:**_____

**For Women: Are you taking birth control:** yes no **Are you pregnant:** yes no

**If yes, how long:**_____**Nursing:** yes no

**Have you ever been treated by a Chiropractic Doctor:** no yes **If yes, for what:**

_____

**To Hospital by:** ☐ Ambulance ☐ Private transportation **by who:**_____

**Name and location of the Hospital:**_____

**What was done at Hospital: X-rays (of what):**_____

**Medication: (what)**_____

**Anything else:**_____

**Have you seen any other doctors / nurses since accident and what was done:**_____

_____

_____

**Has your condition been getting:** ☐ worse ☐ staying the same ☐ better

**Indicate the areas of pain/stiffness that still exist as a result of this accident:**

☐ neck ☐ shoulders ☐ middle back ☐ lower back ☐ hand ☐ wrist ☐ elbow

☐ arm ☐ hip ☐ buttock ☐ thigh ☐ knee ☐ leg ☐ ankle ☐ chest ☐ jaw

**Indicate other symptoms as a result of this accident:**

☐ headaches ☐ dizziness ☐ ringing in ears ☐ memory loss ☐ blurred vision

☐ nausea ☐ tension ☐ fatigue ☐ numbness/tingling (where)_____

**Weight**:____lbs **Height:**_____

**Other symptoms or comments:**

_____

_____

_____

_____

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**Patient Medical History:** ☐ Motor Vehicle Accident ☐ Work Related Accident ___/___/_____.

**Surgical History:** ☐ Yes ☐ No ☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Shoulder ☐ Knee Rt Lt

Other:_____

Illness: ☐ Diabetes ☐ Hypertension ☐ Myocardial Infarction ☐ COPD ☐ Stroke ☐ Cancer
☐ MS ☐ Other:_____

**Family Medical History:** ☐ Diabetes ☐ Hypertension ☐ Myocardial Infarction ☐ COPD
☐ Stroke ☐ Cancer ☐ MS ☐ Other:_____

**Workers Compensation Injuries**
**Injuries involving Lifting:**

From where were you lifting the object?

() Ground level () Below ground level () A surface about 1 to 2 feet off the ground
() A surface about 2 to 3 feet off the ground () A surface about 3 to 5 feet off the ground
() A surface above 5 feet off the ground

() Other:_____

How many pounds was the object you were lifting?

() 1 to 5 pounds () 5 to 10 pounds () 10 to 20 pounds () 20 to 40 pounds
() 40 to 60 pounds ()60 to 80 pounds () 80 to 100 pounds () over 100 pounds
() Other:_____

What position were you in while lifting the object?

() Back was in an upright/straight position () Position was bent over at the waist
() Position was twisted to the left side () Position was twisted to the right side
() Other:_____

What type of pain did you feel immediately after the injury?

() A gripping pain () A sharp pain () A dull pain () An achy pain
() A popping feeling () Other:_____

**Injuries involving Falling:**

Where at work did you fall?
() Onto the ground while walking
() Onto the ground while running
() From a surface 1 to 3 feet off the ground
() From a surface 3 to 6 feet off the ground
() From a surface 6 to 9 feet off the ground
() From a surface higher than 9 feet off the ground
() Other:_____

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What part of your body did you land on? Selection:____ (choose from below list)
What other areas were injured as a result of your fall? Selection:___ (choose from below list)

(A) Head (C) Right Shoulder (E) Right arm (G) Right Hand (B) Neck (D) Left shoulder (F) Left arm
(H) Left Hand (I) Back (J) Right buttock (L) Tail bone (N) Left hip (P) Left Leg (K) Left buttock
(M) Right hip (O) Right leg (Q) Right knee (Q) Right knee (S) Right foot (R) Left knee (T) Left foot

**Other work related injuries:**

Other type of accident (if not caused by lifting or a fall)?

() Raised up from bending over () Suffered a wrist injury from repetitive use
()Twisted at the waist ()Suffered a wrist injury from pulling

**Job Analysis:**

What regular activities to you perform at your job?
() Bending and stooping () Crawling () Reaching above the shoulders () Squatting
() Climbing () Crouching () Kneeling () Maintaining an awkward posture () Pushing and pulling

How much do you regularly lift at your job?

() 1 to 10 pounds () 20 to 40 pounds () 60 to 80 pounds
() 10 to 20 pounds () 40 to 60 pounds () 80 to 1000 pounds () Over 100 pounds

Are you required to regularly bend over while lifting at your job?

() Yes
() No

Are your hands subject to repetitive movements? Such as?

() Light grasping with the left hand () Firm grasping with the right hand
()Light grasping with both hands () Firm grasping with the left hand
() Light grasping with the right hand () Firm grasping with both hands
() Typing () Using a computer mouse

How many hours are you required to regularly perform each of the following activities at your job?

Sitting _____hrs Standing _____hrs
Walking_____hrs Lifting _____hrs

Check below if applicable:

() Did you report this injury in writing at work?
() Have you seen another health care provider since the accident?

***PATIENT'S SIGNATURE:***_____