National Pike
CHIROPRACTIC

Workers Compensation History

Date:__________________________

Name____**Date of Accident**________________

1: Name of employer at time of accident: ____

2: Length of employment prior to accident: _______________________________________

3: Type of work being done at the time of injury: __________________________________

4: In your own words, please describe the accident: ________________________________

5: have you been treat by another doctor of this accident? ( ) YES ( ) NO

If yes, please list the 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 medications are you taking? ____

Do these medications 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__________________________

Does the physical therapy help? ( ) YES ( ) NO ( ) Don't know

9: Prior to this accident, have you ever had any physical complaints similar to what you have now?

( ) YES ( ) NO ( ) Don't know

If yes, describe:____

Were these similar complaints the result of a previous accident(s)? ( ) YES ( ) NO

If yes, please provide details of the accident:__________________________________

10: Have you had any of the 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 0( ) NO

15: Have you returned to work since your accident, please fill out the information below:

DATE	EMPLOYER	OCCUPATION	LIGHTDUTY REG. DUTY	FULL- TIME PART- TIME

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

4: My pain goes into my: ( ) Right leg ( ) Left Leg ( ) Both

5: I have tingling and/or numbness in my: ( ) Right leg ( ) Left leg ( ) Both

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 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

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	
6: My pain wakes my 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 complaint you are experiencing that were not previously covered on this questionnaire, or list any additional comments regarding your condition:

____
____
____
____
____
____
____
____
____

JOB DESCRIPTION

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

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

2: On the job, I perform the following activities: (In terms of an 8-hour workday, "Occasionally"= 33%, "Frequently"= 34-66%, and "Continuously"= 67-100% of the day.)

	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	( )	( )	( )	( )
11-24 pounds	( )	( )	( )	( )
25-34 pounds	( )	( )	( )	( )
35-50 pounds	( )	( )	( )	( )
51-74 pounds	( )	( )	( )	( )
75-100 pounds	( )	( )	( )	( )

4: Do you have to bend over while doing any lifting? ( ) Yes ( ) No

5: Are your feet used for repetitive actions, such as operating foot controls? ( ) Yes ( ) No

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

	SIMPLE GRASPING	**FIRM GRASPING**	**FINE MANIPULATING**
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 changes 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 gases? ( ) Yes ( ) No

Describe: ____

12: Please list any additional comments: ______________________________

Patient Signature____Date_____________________