

## Job Related Injury Information

Patient Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### About the Accident

Date and time of accident: \_\_\_\_\_ [ ] a.m. [ ] p.m.

Was your accident directly related to your work? [ ] Yes [ ] No

Briefly describe the events that occurred just before and during your accident:

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Give the address where the accident occurred: (if other than employer's address)

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Was anyone else present during your accident? [ ] Yes [ ] No

Did you report your accident to your employer? [ ] Yes [ ] No

What recommendations did your employer make just after your accident?

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Has this type of accident happened to you before? [ ] Yes [ ] No

To the best of your knowledge, has this accident occurred in your workplace before? [ ] Yes [ ] No

In general:

Is your job physically stressful? [ ] Yes [ ] No

Is your job mentally stressful? [ ] Yes [ ] No

Is your workplace noisy? [ ] Yes [ ] No

Have you changed jobs in the last year? [ ] Yes [ ] No

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### After Injury

Did accident render you unconscious?  Yes  No

If yes, for how long? \_\_\_\_\_

Please describe how you felt immediately after the accident: \_\_\_\_\_

Have you gone to a hospital or seen any other Doctor?  Yes  No

When did you go?  Just after accident  The next day  2 days plus  \_\_\_\_\_

How did you get there?  Ambulance  Private transportation

Name of hospital and/ or attending doctor: \_\_\_\_\_

Was he/she a:  D.C.  M.D  D.O  D.D.S

Describe any treatment you received: \_\_\_\_\_

Were X-Rays taken?  Yes  No

Was medication prescribed?  Yes  No If yes, list \_\_\_\_\_

Have you been able to work since this injury?  Yes  No

Are your work activities restricted as a result of this injury?  Yes  No

Indicate the symptoms that are a result of this accident:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Dizziness      | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Arms/ shoulder pain | <input type="checkbox"/> Back pain       |
| <input type="checkbox"/> Memory loss    | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Numb hands          | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> Headache(s)    | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Back stiffness  |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Tension             | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Leg pain        |
| <input type="checkbox"/> Buzzing in ear | <input type="checkbox"/> Neck pain           | <input type="checkbox"/> Stomach upset       | <input type="checkbox"/> Numb feet/ toes |
| <input type="checkbox"/> Ears ringing   | <input type="checkbox"/> Neck stiff          | <input type="checkbox"/> Jaw problems        | <input type="checkbox"/> Nausea          |

Other \_\_\_\_\_

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lovemaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Is your condition getting worse?  Yes  No  Constant  Comes and goes

Have you retained an attorney:  Yes  No

If yes, whom? \_\_\_\_\_

His/ Her phone #: \_\_\_\_\_

### Recovery

How many hours are in your normal workday? \_\_\_\_\_

Please indicate on your daily job duties and any activities, which you are occasionally asked to perform.

Standing

Driving

Operating equipment

Sitting

Twisting

Work with arms above head

Walking

Crawling

Typing

Lifting

Bending

Stooping

Other \_\_\_\_\_

What positions can you work in with minimum physical effort and for how long?

\_\_\_\_\_  N/A

Prior to the injury were you able to work on an equal basis with others your age?  Yes  No  N/A

Do you work with others who can help you with any heavy lifting?  Yes  No  N/A

While in recovery, is there any light duty work you could request?  Yes  No  N/A

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature Parent or Guardian (if minor)

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date