PURPOSE CHIROPRACTIC

2850 National Drive Suite 105, Onalaska, WI, 54650
(608) 519-5767 www.purposechiro.com

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:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY 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 ( ) 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
6. My pain wakes me up during the night .....( ) Yes ( ) No

Neck Pain (continued):

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: _____
_____
_____

Signature _____ Date _____

PURPOSE CHIROPRACTIC
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Date of accident:

Worker:

Employer's Name:
Employer's Address:
Employer's Phone:

Insurance Carrier:
Address:
Phone:

Foreman or Immediate Supervisor:

The above employee has advised me of his work-related injury. This is your authorization to render him treatment at Purpose Chiropractic.

_____
Print Name

_____
Signature

_____
Title–Authorized Representative of Employer

Date _____