Chiropractic Wellness Workers Compensation Intake Form

File Number (Office Use) _________

Patient Information:

Today's Date ____________________
Name ____________________
I prefer to be called ____________________
Address ____________________
____
____
Sex ▯ **Male** ▯ **Female**
Occupation ____________________
Employer ____________________

Home Phone ____________________
Work Phone ____________________
Email ____________________
Social Security No. ____________________
Date of Birth ____________________
Height ____' ____" Weight ______ lbs
Marital Status ____________________
No of Children ____________________

Address ____________________
If minor, name of parent or guardian ____________________
Who should we contact in case of an emergency? ____________________
Relation ____________________ Phone ____________________
Address ____________________
Attorney ____________________ Phone ____________________
Primary Care Physician ____________________ Phone ____________________
How did you hear about our office? ____________________
Have you ever been to a chiropractor before? ▯ **YES** ▯ **NO** If so, whom? ____________________

Accident Information:

Date ____________ Time ________ AM PM
Was your accident directly related to your work? ▯ **YES** ▯ **NO**
Were there witnesses? ▯ **YES** ▯ **NO**
Did you report the accident to your employer? ▯ **YES** ▯ **NO**
What recommendations did your employer make just after your accident? ____________________
____
Please give the address where the accident occurred (if other than employer's address) ____________
____
Briefly describe the events that happened just before and during your accident ____________
____
Please describe the pain and its location ____________________
____
Has this type of accident happened to you before? ▯ **YES** ▯ **NO**
To the best of your knowledge, has this accident happened 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 changes jobs in the last year? ▯ YES ▯ NO

Post-Injury Information:

Have you seen any other doctor(s) since the accident? ▯ **YES** ▯ **NO** Name ____________

When did you go? ▯ **IMMEDIATELY** ▯ **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.**

Please describe any treatment you received ____________

Were X-Rays done? ▯ **YES** ▯ **NO** An MRI? ▯ **YES** ▯ **NO** CAT scan? ▯ **YES** ▯ **NO**

Was medication prescribed? ▯ **YES** ▯ **NO** If yes, what? ____________

Have you missed any work since the accident? ▯ **YES** ▯ **NO** Date(s) ____________

Are your work activities restricted as a result of your injury? ▯ **YES** ▯ **NO**

Indicate the symptoms that are a result of this accident:

▯ **DIZZINESS**	▯ **DIFFICULTY SLEEPING**	▯ **JAW PROBLEMS**	▯ **NAUSEA**
▯ **MEMORY LOSS**	▯ **ARM/SHOULDER PAIN**	▯ **IRRITABILITY**	▯ **BACK PAIN**
▯ **HEADACHE(S)**	▯ **NUMB HANDS/FINGERS**	▯ **FATIGUE**	▯ **LOW BACK PAIN**
▯ **BLURRED VISION**	▯ **TENSION**	▯ **CHEST PAIN**	▯ **BACK STIFFNESS**
▯ **BUZZING IN EAR**	▯ **NECK PAIN**	▯ **SHORT BREATH**	▯ **LEG PAIN**
▯ **EARS RINGING**	▯ **NECK STIFF**	▯ **STOMACH UPSET**	▯ **NUMB FEET/TOES**

▯ **OTHER** ____________

Did you ever experience similar symptoms prior to the accident? ▯ **YES** ▯ **NO**

Has your condition ▯ **IMPROVED** ▯ **WORSENED** or ▯ **STAYED SAME** since the accident?

Is your condition affecting your ▯ **WORK** ▯ **SLEEP** or ▯ **DAILY ROUTINE**? Please explain ____________

Please indicate your degree of difficulty (on a scale of 1-5, with 1 being comfortable, 3 being uncomfortable, and 5 being painful) in performing the following activities:

___ Lying on Back	___ Lying on Side	___ Lying on stomach	___ Sitting
___ Standing	___ Stretching		___ Walking
___ Running	___ Sports	___ Working	___ Lifting
___ Bending	___ Kneeling	___ Pulling	___ Reaching

Patient Signature ____________ **Date** ____________