Sheldon Road Chiropractic & Massage Therapy

Worker's Compensation History

Patient _____ Date_____

Name of Compensation Carrier: _____ Phone ( ) _____

Address of Carrier: _____ City _____ State _____

Employer's Name: _____ Phone ( ) _____

Employer's Address: _____ City _____ State _____

1. Type of Business _____ Your Occupation _____
2. Date Injured _____ Hour _____ AM/PM Last Date Worked _____
3. Are you off work? □ Yes □ No Previous Worker's Compensation Injury? □ Yes □ No
4. Accident reported to employer? □ Yes □ No Name of person reported accident to _____
5. Injured at: _____ City: _____ State: _____ Zip: _____
6. Length of time worked there prior to accident: _____
7. Type of work being done at time of injury: _____
   _____
8. In your own words, please describe accident: _____
   _____
   _____
9. 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? _____
10. Are you: Improved Unchanged Getting worse
11. What types of medicines are you taking? _____
    _____
    Do these medicines help? Yes No Don't know
12. 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: _____

13. 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 result of a previous accident(s)? Yes No
    Please provide details of accident(s): _____
    _____
    _____
14. Have you ever had any other serious accidents which required medical care? Yes No
    Describe: _____
    _____
    _____

15. Have you had any serious illnesses that required hospitalization? Yes No
Describe: _____
_____
_____

16. Have you had any surgeries? Yes No
If yes, list type of surgery and date: _____
_____
_____

17. Have you had any nervous or mental illnesses? Yes No
Have you had psychiatric care? Yes No
18. Have you received an medical discharge from the Armed Forces? Yes No
19. 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 /Reg. Duty	Full/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 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
Walk	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
7. Change 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 movements, such as:

	Simple grasping	Firm grasping	Fine manipulating
Right hand			
Left hand			

7. Are you required to work in 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**