180° Chiropractic

Work Accident History

Please Print

Patient Information

Acct# _____

○ Dr. ○ Mr. ○ Mrs. ○ Ms. ○ Miss Marital status: ○ M ○ S ○ W ○ D

Last Name | First Name | Middle Initial | Nick Name

Address | City | State | Zip Code

Home phone: _____ Mobile Phone: _____

Email address: _____

Social Security No.: _____ Date of Birth: _____ Sex: ○ M ○ F

Occupation: _____ Employer: _____

Work Address: _____ Work Phone: _____

Person to contact in an emergency: _____ Phone: _____

Employer Information

Company Name | Supervisor Name | Work Phone#

Address | City | State | Zip Code

Nature of business (eg., food manufacturing, building construction, retailer of women's clothes)

Insurance Information

If you have any insurance information please provide the staff with your insurance card and/or required forms.

Accident/Injury History

1. Date of Accident/Injury: _____ ○ Gradual ○ Sudden ○ Progressive

2. Address/location where you were injured: _____

No. and Street | City | County

3. Time of day when accident occured: _____ am/pm Date last worked: _____

4. Did you report this to you employer? ○ **Y** ○ **N** If so, to whom? _____

5. Did you go to the hospital or another doctor's office after the accident? ○ **Y** ○ **N**
   If so, where: _____ Were X-rays taken? ○ **Y** ○ **N**
   What type of treatment was administered? _____
   Was a diagnosis made? ○ **Y** ○ **N** If so, what was it? _____

6. Describe how the accident/injury happened: _____

7. What is your number-one problem or the one area of greatest pain? _____

8. Have you ever experienced this problem before? ○ **Y** ○ **N** When? _____

9. Please rate the level of this pain on the following scale: 0 is no pain, 10 is severe pain or the worst pain you have ever felt. If your pain varies from day to day please circle two numbers to indicate a range of your pain. 0 1 2 3 4 5 6 7 8 9 10

10. How often do you experience the pain?

○ 1-2 hours per day ○ About half of the day ○ Most of the day ○ The pain never goes away

11. How does the pain effect your daily activities?

○ It does not effect my daily work or home activities.

○ I have had to change how I do my work or home activities. Please explain: _____

○ I cannot do the following due to my present problem: _____

○ I am unable to do nearly everything I am accustomed to doing.

12. What increases your pain? _____

13. What decreases your pain? _____

14. List any other complaints currently bothering you and rate your pain level for each.

a. _____ 0 1 2 3 4 5 6 7 8 9 10
b. _____ 0 1 2 3 4 5 6 7 8 9 10
c. _____ 0 1 2 3 4 5 6 7 8 9 10
d. _____ 0 1 2 3 4 5 6 7 8 9 10

15. Do you feel you could perform your usual job right now? ○ **Y** ○ **N**

16. Describe your routine job duties: _____

17. If you are working, how has your current condition affected your normal duties? _____

18. Is there any activity or duty you are unable to perform? _____

19. How often does your job require you to do the following:

○ Lifting (_____ lbs) ○ Sitting (_____ hrs/day) ○ Standing (_____ hrs/day)
○ Computer (_____ hrs/day) ○ Telephone (_____ hrs/day) ○ Driving (_____ hrs/day)

○ Push/pull:	☐ Once in a while	☐ Often	☐ Frequently	☐ Almost all the time
○ Reach overhead:	☐ Once in a while	☐ Often	☐ Frequently	☐ Almost all the time
○ Grasping:	☐ Once in a while	☐ Often	☐ Frequently	☐ Almost all the time
○ Twisting/bending:	☐ Once in a while	☐ Often	☐ Frequently	☐ Almost all the time
○ Squatting/kneeling:	☐ Once in a while	☐ Often	☐ Frequently	☐ Almost all the time
○ Walking:	☐ Once in a while	☐ Often	☐ Frequently	☐ Almost all the time
○ Climbing/ladders:	☐ Once in a while	☐ Often	☐ Frequently	☐ Almost all the time

○ Other Please explain: _____

20. Have you ever been injured at work prior to this accident/injury? ○ **Y** ○ **N** When? _____
Please explain: _____

21. Have you ever been involved in an automobile accident before? ○ **Y** ○ **N** When? _____
Were you injured? ○ **Y** ○ **N** Please explain: _____

22. List all surgeries you have had (with date) _____

23. List all medication you are currently taking (prescribed and over the counter) _____

24. Please add anything else you would like the doctor to know: _____

If you have experienced any of the following conditions in the past mark a "P" on the line provided. If you are currently experiencing any of the following conditions please mark a "C" on the line provided. (check all that apply)

○ heart attack	○ stroke	○ arthritis	○ gall bladder trouble
○ diabetes	○ glaucoma	○ fainting spells	○ kidney stones
○ difficulty with urination		○ bloody stools	○ difficulty with bowel movements
○ prostate trouble	○ anemia	○ cancer	○ asthma
○ AIDS	○ ulcers	○ diverticulosis	○ menstrual cramping
○ dizziness	○ loss of memory	○ chest pain	○ shortness of breath
○ constipation	○ diarrhea	○ general fatigue	○ sudden weight loss
○ nausea	○ muscle cramping	○ soreness in joints	○ loss of hearing
○ ears ringing	○ headache	○ migraine	○ epilepsy
○ gout	○ tuberculosis	○ syphilis	○ sprained ankle ○ R ○ L
○ knee/hip replacement		○ broken bones (specify) _____	

General Activities (check all that apply)

○ sleep on waterbed	○ read in bed	○ fall asleep in recliner/on couch		○ diabetes
○ glaucoma	○ fainting spells	○ kidney stones	○ sleep on stomach	○ needlepoint/knitting
○ use two or more pillows to sleep with		○ sewing	○ lift weights/wt. mach.	
○ play video games (__ hrs per day)		○ exercise _____x/wk		○ jog _____ x/wk
○ computer use (____ hrs per day)		○ swim	○ use healthrider	○ watch television (____ hrs per day)

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Patient's Signature _____ Date _____

Doctor's Comments: _____