

WORK ACCIDENT HISTORY

PLEASE PRINT

Patient Information	Асст#	Асст#						
ODR. OMR. OMRS. OMS. OMISS	Marital status: ON	S OW OD						
Last Name	First Name	MIDDLE INITIAL	Νιςκ Ναμε					
Address	Сіту	State	ZIP CODE					
Home phone:	Mobile Phone:							
Email address:								
Social Security No.:	Date of Birth: Sex: O M							
Occupation:	Employer:							
Work Address:	Work Phone:							
Person to contact in an emergency:	Phone:							
Employer Information								
Company Name	Supervisor Name	Work Ph	IONE#					
Address	Сітү	State	ZIP CODE					
Nature of business (eg., food manufacturi	NG, BUILDING CONSTRUCTION, RETAILER OI	women's clothes)						
Insurance Information								
IF YOU HAVE ANY INSURANCE INFORMATION PLE	ASE PROVIDE THE STAFF WITH YOUR INSUR	ANCE CARD AND/OR REQUIRED FOR	M5.					
Accident/Injury History								
1. Date of Accident/Injury:	DATE OF ACCIDENT/INJURY: O Gradual O Sudden							
2. Address/location where you were injured:								
No. and Street	Сіту	County						
3. Time of day when accident occured:	am/pm Date la	st worked:						
4. Did you report this to you employer?	Y ON If so, to whom?							
 5. Did you go to the hospital or another doct If so, where:	?	Were X-rays taken? O Y						
6. Describe how the accident/injury happen	ed:							
7. What is your number-one problem or the	one area of greatest pain?							

a. Please rate the level of this pain on the following scale: o is no pain, to is severe pain or the worst pain you have ever fielt. If your pain varies from day to day please circle two numbers to indicate a range of your pain. o 1 2 3 4 5 6 7 8 9 10 a. How often do you experience the pain? o 1 2 3 4 5 6 7 8 9 10 a. How often do you experience the pain? o 1 2 3 4 5 6 7 8 9 10 a. How often do you experience the pain? o 1 2 3 4 5 6 7 8 9 10 a. How often do you experience the pain? i 1 1 2 3 4 5 6 7 8 9 10 a. How often the pain effect your daily activities. i 1 1 2 3 4 5 6 7 8 9 10 a. What decreases your pain? a. d 0 1 2 3 4 5 6 7 8 9 10 a. d 0 1 2 3 4 5 6 7 8 9 10 a. d 0 1 2 3 4 5 6 7 8 9 10 a. d 0 1 2 3 4 5 6 7 8 9 10 b. d <th>8. Have you ever experienced</th> <th>this problem before</th> <th>e? 🛛 Y</th> <th>O N</th> <th>Wh</th> <th>en?</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th>	8. Have you ever experienced	this problem before	e? 🛛 Y	O N	Wh	en?								
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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)

O heart attack	stroke	O arthritis	gall bladder trouble			
O diabetes	🔾 glaucoma	 fainting spells 	kidney stones			
 difficulty with urination 		bloody stools	O difficulty with bowel m	novements		
O prostate trouble	O anemia	○ cancer	O asthma			
O AIDS	O ulcers	O diverticulosis	O menstrual cramping			
O dizziness	Ioss of memory	Chest pain	shortness of breath			
 constipation 	O diarrhea	general fatigue	Sudden weight loss			
O nausea	O muscle cramping	o soreness in joints	Ioss of hearing			
O ears ringing	O headache	O migraine	○ epilepsy			
○ gout	O tuberculosis	Syphilis	o sprained ankle O R O L			
knee/hip replacement		D broken bones (specify)				
l Activities (check all that	apply)					
Sleep on waterbed	O read in bed	 fall asleep in recliner/on couch 		🗅 diabetes		
O glaucoma	 fainting spells 	kidney stones	Sleep on stomach	needlepoint/knitting		
use two or more pillows to sleep with		sewing	 lift weights/wt.mach. 			

o exercise ______x/wk

use healthrider

□ swim

computer use (_____ hrs per day)

○ play video games (__ hrs per day)

🗆 jog _____

• watch television (______

x/wk

hrs per day)

General

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:	