Vissers Chiropractic

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Workers' Compensation History

Name:______________________________ Date:__________

Employer's Name:______________________________ Ph #:__________

Type of Business:______________________ Your Occupation:__________

Date Injured:__________ Hour:______ AM / PM Last Date Worked:__________

Are you currently off work? ☐ Y ☐ N Length of time worked there prior to injury:__________

Location of injury:______________ City:__________ State:____ Zip:______

Type of work being done at the time of injury:______________________________

In your own words, please describe what happened:______________________________

____

Injury reported to employer? ☐ Y ☐ N Name of person reported to:__________

Workers' Comp Claim #:______________ Claims Adjuster:__________

Workers' Comp Ins Carrier:______________________ Ph #:__________

Workers' Comp Ins Add:______________ City:__________ State:___ Zip:______

Have you been treated by another doctor for this injury? ☐ Y ☐ N If yes, list doctor's name and address:

____

What type of treatment did you receive?______________________________

How long were you treated by this doctor?______________________________

Are you: ☐ Improved ☐ Unchanged ☐ Getting Worse

Are you taking any medications? ☐ Y ☐ N What kind?______________________________

Are you receiving physical therapy? ☐ Y ☐ N If yes, how often? ☐ Daily ☐ Every other day

☐ Several times a week ☐ Weekly ☐ Every other week ☐ Monthly ☐ Other

Does the physical therapy help? ☐ Y ☐ N ☐ Don't know

Prior to this injury, have you ever had any physical complaints similar to what you have now?

☐ Y ☐ N ☐ Don't know If yes, please describe:______________________________

____

Were these similar complaints the result of a previous injury? ☐ Y ☐ N Please provide details of injury:

____

Have you had any serious accidents which required medical care? ☐ Y ☐ N Describe:__________

____

Have you had any serious illnesses that required medical care? ☐ Y ☐ N Describe:__________

____

Have you had any surgeries? ☐ Y ☐ N If yes, list type of surgery and date:__________

____

____

Have you returned to work since this injury? ☐ Y ☐ N

If you have returned to work since your injury, please fill out the information below:

In a typical 8-hour workday, I: (Circle the number of hours per 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

(In terms of an 8-hour workday, "occasionally" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day).

On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINOUSLY
Bend / stoop	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Balancing	☐	☐	☐	☐
Pushing/pulling	☐	☐	☐	☐

Do you have to bend over while doing any lifting? ☐ Y ☐ N

Are your feet used for repetitive movements, such as in operating foot controls? ☐ Y ☐ N

Do you use your hands for repetitive actions, such as:

	SIMPLE GRASPING	FIRM GRASPING	FINE MANIPULATING
Right Hand	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Left Hand	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

Are you required to work on unprotected heights? ☐ Y ☐ N Describe:________________

Are you required to be around moving machinery? ☐ Y ☐ N Describe:________________

Are you exposed to marked changes in temperature and humidity? ☐ Y ☐ N Describe:________________

Are you required to drive automotive equipment? ☐ Y ☐ N Describe:________________

Are you exposed to dust, fumes, and/or gases? ☐ Y ☐ N Describe:________________

Please list any additional comments:________________

Signature

Date

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Patient Symptom Form – Initial

Name____________________________________ **Date**__________________

Complaint	Area #1	Area #2	Area #3
How are you feeling today? 0 = no pain thru 10 = much pain			
Does the pain travel anywhere? Where?			
Date pain began?			
How did the pain begin?			
How often does it hurt?			
What makes the pain worse?			
What makes the pain less?			
What can't you do that you did before the pain started?			
Have you tried anything at home to relieve the pain?			
Have you seen any other Doctors for it? Who? When?			
What did Doctors Advise?			
Have you had this pain before? When?			

Pain Drawing

Please indicate the location of pain and the symbol that best describes the discomfort you are feeling.

Type of Pain	Symbol
Sharp / Stabbing	+++++++
Dull / Achy	VVVVV
Pins / Needles	OOOOO
Numbness	/ / / / /