Potomac Valley Chiropractic – Work Injury Form

Please answer all questions **completely.**

Name: ___________________________________ D.O.B. __________________

Address: ______________________________ City ____________________ State _______ Zip ____________

Home Phone: ________________________ Cell #:______________________________ Work #:___________________________

Occupation: _________________________ Marital Status: M S W D

Number of children: _____ Boys _____ Girls

Name and Number of Emergency Contact: ____

* *

Name of Employer: _________________________

Address of Employer: _________________________ City _________________ State ________ Zip ___________

Name and Number of Supervisor: ____

Falling Accidents Only

Date and Time of Accident: _______________________________________ **Location:** _________________________________

Please Describe the Accident:____

Where did you fall?

___ Down the stairs ___ From 4 feet high ___ From 8 feet high

___ From a ladder ___ From higher than 8 feet ___ Onto the ground

What part of the body got impacted? ____

Other body areas affect? ____

After the Accident

Please describe the type and location where you feel pain (*Please be specific*): ____

____

Additional Symptoms:

___ Headaches ___ Inflammation ___ Lower back aches

___ Other, please specify: ________________________

How long did it take to feel your additional symptoms?

___ Immediately ___ 5 minutes ___ One hour ___ One day ___ Several days

Other comments: ____

Did you lose consciousness after the injury? ___Yes ___No

Did you receive emergency care after the accident? ___Yes ___No

Where did you go immediately after the accident? ________________________________

Job Description

Please check any of the following that are incorporated in your regular work activities.

___ Bending ___ Climbing ___ Crawling ___ Driving ___ Kneeling

___ Lifting ___ Pulling ___ Pushing ___ Reaching ___ Running

___ Sitting ___ Squatting ___ Standing ___ Walking

Past Health History

Please check any past/current illness:

___ Hypertension ___ Arthritis ___ Diabetes ___ Heart Disease
___ Anxiety ___ Cancer: Type _________ ___ Tuberculosis ___ Headaches
___ Depression ___ Seizure Disorder ___ Asthma ___ Migraines
___ Allergies ___ Osteoporosis ___ Carpel Tunnel ___ Hernia

Please check any current medications you are taking:

___ Hypertensives ___ Diabetic/Insulin ___ Cholesterol Lowering ___ Cholesterol Killers
___ Pain Killers ___ Tylenol/Advil ___ Allergy ___ Aspirin
___ Asthma ___ Steroid/Anti-inflammatory ___ Others: ______________________

Past Surgeries:

Major surgery What/When: ____
Minor surgery What/When: ____

Is this complaint related to an injury at work? ___ Yes ___ No
Is this complaint related to a car accident? ___ Yes ___ No

Past Automobile Accidents ___ < 1 yr ___ < 2 – 3 yrs. ___ > 5 yrs.
Year: ____________ Brief Description: ________________________________

Family History

Check any that apply to your family history.

___ Mental Illness ___ Cancer: Type ____________ ___ Diabetes ___ Heart Disease
___ Obesity ___ Arthritis ___ High Blood Pressure
___ Osteoporosis ___ Other: ___________

Do any family member have a physical impairment? ___ Yes ___ No
Parents are: ___ Deceased ___ Alive

Does current problem interfere with:

___ Driving ___ Sleeping ___ Lifting Children ___ Computer work ___ Bending ___ Standing
___ Housework ___ Exercise ___ Sitting ___ Running ___ Grooming ___ Twisting
___ Other (Describe): __________________________________

Insurance Information

Name of Worker's Comp Carrier: ____
Insurance Company Address: ____
____
Name of Claim Adjuster: ____
Phone # of Claim Adjuster: _________________________________ Fax #:_________________________________
CLAIM NUMBER: ____

I understand and agree that Worker's Compensation policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the Worker's Compensation carrier and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____________________________ Date ________________

Guardian's Signature (if minor): __________________

Doctor's Signature: ____________________________