

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: _____

Use for Non-Lifting or Falling Injuries

After the injury, you immediately felt:
 Dull pain Sharp pain Tearing Other: _____

Where did you develop pain?
 Left knee Left shoulder Lower back Neck
 Right knee Right shoulder

Additional injuries:
 Twisted at the waist Wrist injury from pulling Wrist injury from pushing
 Wrist injury from repetitive use

Indicate areas of lacerations:
 Left elbow Left forearm Left knee
 Right elbow Right forearm Right knee

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.

<input type="checkbox"/> Bending	<input type="checkbox"/> Climbing	<input type="checkbox"/> Crawling	<input type="checkbox"/> Driving	<input type="checkbox"/> Kneeling
<input type="checkbox"/> Lifting	<input type="checkbox"/> Pulling	<input type="checkbox"/> Pushing	<input type="checkbox"/> Reaching	<input type="checkbox"/> Running
<input type="checkbox"/> Sitting	<input type="checkbox"/> Squatting	<input type="checkbox"/> Standing	<input type="checkbox"/> 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: _____