Aspenridge Chiropractic Center

WORK / COMP HISTORY

Patient Phone ( )

Address City State Zip

Age Birthdate Sex S/S #

Name of Compensation Carrier Phone ( )

Address of Carrier City State Zip

Employer's Name Phone ( )

Employer's Address City State Zip

1. Type of Business Your Occupation
2. Date Injured Hour AM/PM Last Date Worked Are you off work? Yes No
3. Previous Workers' Compensation Injury? Yes No
4. Accident reported to employer? Yes No Name of person reported accident to
5. Injured at: City State Zip
6. Length of time worked there prior to accident:
7. Type of work being done at time of injury:
8. In your own words, please describe accident:
9. Have you been treated by another doctor for this accident? Yes No
   If yes, please list doctor's name and address:

   What type of treatment did you receive?

   How long were you treated by this doctor?
10. Are you: Improved unchanged getting worse
11. What types of medicines are you taking?

    Do these medicines help? Yes No Don't know
12. Have you had physical therapy? Yes No If yes, how often?
    Daily Every other day Several times a week Weekly Every other week Monthly
    Other
13. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?
    Yes No Don't know
    If yes, describe:

    Were these similar complaints the results of a previous accident(s)? Yes No
    Please provide details of accident(s):
14. Have you had any other serious accidents which required medical care? Yes No
    Describe:
15. Have you had any serious illnesses that required hospitalization? Yes No
    Describe:
16. Have you had any surgeries? Yes No
    If yes, list type of surgery and date:

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17. Have you had any nervous or mental illness? Yes No

Have you had psychiatric care? Yes No

18. Have you received a medical discharge from the Armed Forces? Yes No

19. Have you returned to work since this accident? Yes No

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

Date	Employer	Occupation	Light Duty Reg. Duty	Full-Time Part-Time

CURRENT MEDICAL COMPLAINTS

BACK PAIN:

1. Currently, I have pain in my:	Low back	Mid back	Upper back
2. My pain began:	Gradually	Suddenly	
3. I have pain:	Sometimes	All of the time	
4. My pain goes into my:	Right leg	Left leg	Both
5. I have tingling and/or numbness in my:	Right leg	Left leg	Both
6. My pain is worse when I:			
Cough or sneeze	Yes	No	
Sit	Yes	No	
Bend	Yes	No	
Walk	Yes	No	
Lift	Yes	No	
Push	Yes	No	
Pull	Yes	No	
7. My back is worse with sexual activity	Yes	No	
8. My pain wakes me up during the night	Yes	No	
9. Changes in the weather affect my pain	Yes	No	

NECK PAIN:

1. My neck pain began:	Gradually	Suddenly	
2. I have pain:	Sometimes	All of the time	
3. My pain goes into my:	Right arm	Left arm	Both
4. I have tingling and/or numbness in my:	Right arm	Left arm	Both
5. My pain is worse when I:			
Cough or sneeze	Yes	No	
Bend forward	Yes	No	
Lift	Yes	No	
Push	Yes	No	
Pull	Yes	No	
Turn my head	Yes	No	
6. My pain wakes me up during the night	Yes	No	
7. Changes in the weather affect my pain	Yes	No	
8. I have neck stiffness	Yes	No	
9. I have headaches	Yes	No	
10. If I do get headaches, they occur:	Sometimes	All of the time	

OTHER PAIN:

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition:

JOB DESCRIPTION

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

1. In a typical 8-hour workday, I: (Circle # of hours / 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

2. On the job, I perform the following activities:

	Not at all	Occasionally	Frequently	Continuously
Bend/stoop				
Squat				
Crawl				
Climb				
Reach above shoulder level				
Crouch				
Kneel				
Balancing				
Pushing/pulling				

3. On the job, I lift:

	Not at all	Occasionally	Frequently	Continuously
Up to 10 lbs				
11-24 lbs				
25-34 lbs				
35-50 lbs				
51-74 lbs				
75-100 lbs				

4. Do you have to bend over while doing any lifting? Yes No
5. Are your feet used for repetitive movements, such as in operating foot controls? Yes No
6. Do you use your hands for repetitive actions, such as:

	Simple Grasping	Firm Grasping	Fine Manipulating
Right hand	Yes No	Yes No	Yes No
Left hand	Yes No	Yes No	Yes No

7. Are you required to work on unprotected heights? Yes No
   Describe:

8. Are you required to be around moving machinery? Yes No
   Describe:

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9. Are you exposed to marked changes in temperature and humidity? Yes No
   Describe:

10. Are you required to drive automotive equipment? Yes No
    Describe:

11. Are you exposed to dust, fumes and/or gases? Yes No
    Describe:

12. Please list any additional comments:

Signature: Date: