Worker's Compensation History

Patient Name: _____ Home Phone: (___) ____-_____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birthdate: ___/___/___ Sex: _____ Cell Phone: (___) ____-_____

Employer's Name: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Phone: (___) ____-_____

Agent: _____ Claim Number: _____

Address: _____ City: _____ State: _____ Zip: _____

1. Type of Business_____ Your Occupation: _____

2. Date of Injury: ___/___/___ Time of Injury: _____ AM/PM Last Date Worked: _____

3. Previous Worker's Compensation Injury? ❑ Yes ❑ No

4. Accident Reported to Employer? ❑ Yes ❑ No Name of Person you Reported the Accident to: _____

5. Injured at: _____ City: _____ State: _____ Zip: _____

6. Length of Time Worked There Prior to Accident> _____

7. Type of Work Being Done at the Time of Injury: _____

8. In your Own Words, Please Describe the Accident:_____
_____
_____
_____

9. Have you Been Treated by Another Doctor for this Accident? ❑ Yes ❑ No If yes, Please List the Doctor's Name and Address:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

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? _____

_____

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: _____
_____
Please Provide the Details of the Accident: _____
_____
_____
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: _____
_____
_____
17. Have you had any nervous or mental illnesses? ❑ 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 to Work since your Accident, Please Fill Out the Information Below:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY REGULAR 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	❑ Right Leg	❑ Both
5. I have tingling and/or numbness	❑ Left 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

NECK PAIN

1. My pain began:
2, I have pain:
3. My pain goes into my:
4. I have ingling and/or numbness in my

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% to 66%, and “continuously” means 67% to 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 POUNDS	❑	❑	❑	❑
11 to 24 POUNDS	❑	❑	❑	❑
25 to 34 POUNDS	❑	❑	❑	❑
35 to 50 POUNDS	❑	❑	❑	❑
51 to 74 POUNDS	❑	❑	❑	❑
75 to 100 POUNDS	❑	❑	❑	❑

4. Do you have to bend over while doing any lifting? ❑ Yes ❑ No

5. Are you rfeet 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: _____

_____

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: ___/___/___

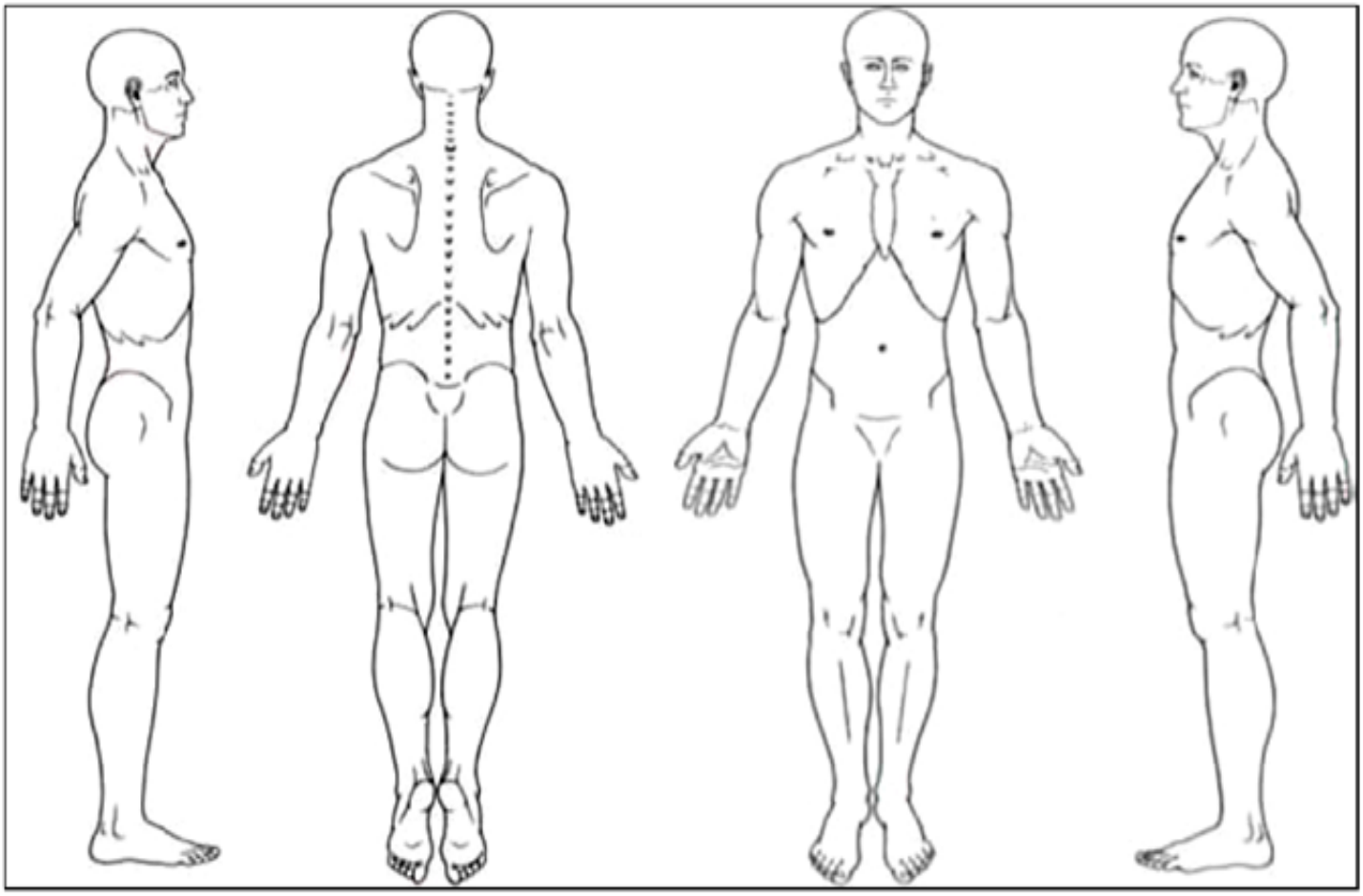
If you have pain, please complete the following. Otherwise skip this page.

SYMPTOM DIAGRAM

Name: _____ Date: ___/___/___

Please be sure to fill this form out extremely accurate. Mark the area(s) on your body where you feel the described sensation(s). Use the appropriate symbol(s). Mark areas of radiating pain and include all affected areas. You may draw on the faces as well.

A = Ache B = Burning N – Numbness P = Pins and Needles S = Stabbing O = Other



Name: _____ Date: ___/___/___

QUADRUPLE VISUAL ANALOGUE SCALE

INSTRUCTIONS: Please circle the number that best describes the question being asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum/maximum using the last 3 months as your reference. If you have completed this form before, indicate your average pain level since the last time you completed this form.

EXAMPLE: I have neck pain, low back pain and a constant headache.

Headache Neck Low Back

No pain_____Worst possible pain.
1 2 (3) 4 5 (6) 7 (8) 9 10

1. What is your pain RIGHT NOW?

No pain_____Worst possible pain.
1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

No pain_____Worst possible pain.
1 2 3 4 5 6 7 8 9 10

3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best?

No pain_____Worst possible pain.
1 2 3 4 5 6 7 8 9 10

4. What is your pain level AT ITS WORST? (How close to "10" does your pain get at its worst)?

No pain_____Worst possible pain.
1 2 3 4 5 6 7 8 9 10

What percentage of your hours awake is your pain at its worst? _____%

Other Comments:

_____

_____

_____

Scarton Chiropractic and Rehabilitation

Name: _____ Date: ___/___/___

If you have a complaint or restriction in your cervical spine (neck), please complete this page. If not, please skip this page.

PLEASE READ INSTRUCTIONS:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Pain Intensity

- ❑ I have no pain at the moment
- ❑ The pain is very mild at the moment
- ❑ The is moderate at the moment
- ❑ The pain is fairly severe at the moment
- ❑ The pain is very severe at the moment
- ❑ The pain is the worst imaginable at the moment

Personal Care (Washing, Dressing etc.)

- ❑ I can look after myself normally, without causing extra pain
- ❑ I can look after myself normally, but it causes extra pain
- ❑ It is painful to look after myself and I am slow and careful
- ❑ I need some help, but manage most of my personal care
- ❑ I need help every day in most aspects of my life
- ❑ I do not get dressed: I wash with difficulty and stay in bed

Lifting

- ❑ I can lift heavy weights without extra pain
- ❑ I can lift heavy weights, but it gives extra pain
- ❑ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, for example on the table
- ❑ I can lift very light weights
- ❑ I cannot lift or carry anything at all

Reading

- ❑ I can read as much as I want to, with no pain in my neck
- ❑ I can read as much as I want to, with slight pain in my neck
- ❑ I can read as much as I want to, with moderate pain in my neck
- ❑ I can hardly read at all, because of severe pain in my neck
- ❑ I cannot read at all

Headaches

- ❑ I have no headaches at all
- ❑ I have slight headaches that come infrequently
- ❑ I have moderate headaches that come infrequently
- ❑ I have severe headaches that come infrequently
- ❑ I have headaches almost allt he time because of pain in my neck

Concentration

- ❑ I can concentrate fully when I want to, with no difficulty
- ❑ I can concentrate fully when I want to, with slight difficulty
- ❑ I have a fair degree of difficulty in concentrating when I want to
- ❑ I have a lot of difficulty in concentrating when I want to
- ❑ I have a great deal of difficulty in concentrating when I want to
- ❑ I cannot concentrate at all

Work

- ❑ I can do as much work as I want to
- ❑ I can do my usual work, but no more
- ❑ I can do most of my usual work, but not more
- ❑ I cannot do my usual work
- ❑ I can hardly do any work at all
- ❑ I can't do any work at all

Driving

- ❑ I can drive my car without any neck pain
- ❑ I can drive my car as long as I want, with slight pain in my neck
- ❑ I can drive my car as long as I want, with moderate pain in my neck
- ❑ I can hardly drive at all, because of severe pain in my neck
- ❑ I can't drive my car at all

Sleeping

- ❑ I have no trouble sleeping
- ❑ My sleep is slightly disturbed (less than 1 hour sleepless)
- ❑ My sleep is mildly disturbed (1-2 hours sleepless)
- ❑ My sleep is moderately disturbed (2-3 hours sleepless)
- ❑ My sleep is greatly disturbed (3-5 hours sleepless)
- ❑ My sleep is completely disturbed (5-7 hours sleepless)

Recreation

- ❑ I am able to engage in all my recreation activities, with no neck pain
- ❑ I am able to engage in all my recreation activities, with some neck pain
- ❑ I am able to engage in most, but not all, of m usual recreation activities
- ❑ I am able to engage in few of my recreation activities, because of severe neck pain

Scarton Chiropractic and Rehabilitation

Name: _____ Date: ___/___/___

If you have a complaint or restriction in your low back, please complete this page. If not, please skip this page.

PLEASE READ INSTRUCTIONS:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Pain Intensity

- ❑ I can tolerate the pain without having to use painkillers
- ❑ The pain is bad but I can manage without taking painkillers
- ❑ The pain is moderate at the moment
- ❑ The pain is fairly severe at the moment
- ❑ The pain is ver severe at the moment
- ❑ The pain is the worst imaginable at the moment

Personal Care (Washing, Dressing ect.)

- ❑ I can look after myself normally, without causing extra pain
- ❑ I can look after myself normally, but it cases extra pain
- ❑ It is painful to look after myself and I am slow and careful
- ❑ I need some help, but manage most of m personal care
- ❑ I need help every day in most aspects of my life
- ❑ I do not get dressed: I wash with difficulty and stay in bed

Lifting

- ❑ I can lift heavy weights without extra pain
- ❑ I can lift heavy weights, but it gives extra pain
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table
- ❑ I can lift very light weights
- ❑ I cannot lift or carry anything at all

Walking

- ❑ Pain does not prevent me from walking any distance
- ❑ Pain prevents me from walking more than one mile
- ❑ Pain prevents me from walking more than 1/2 mile
- ❑ Pain prevents me from walking more than 1/4 mile
- ❑ I can only walk using a stick or crutches
- ❑ I am in bed most of the time and have to crawl to the toilet

SITTING

- ❑ I can sit in any chair as long as I like
- ❑ I can only sit in my favorite chair for as long as I like
- ❑ Pain prevents me from sitting more than 1 hour
- ❑ Pain prevents me from sitting more than 30 minutes
- ❑ pain prevents me from sitting more than 10 minutes
- ❑ Pain prevents me from sitting most of the time

Standing

- ❑ I can stand as long as I want without extra pain
- ❑ I can stand as long as I want but it gives extra pain
- ❑ Pain prevents me from standing for more than 1 hour
- ❑ Pain prevents me from standing for more than 30 minutes
- ❑ Pain prevents me from standing for more than 10 minutes
- ❑ Pain prevents me from standing at all

Sleeping

- ❑ Pain does not prevent me from sleeping well
- ❑ I can sleep well only by using tablets
- ❑ Even when I take tablets I have less than 6 hours sleep
- ❑ Even when I take tablets I have less than 4 hours sleep
- ❑ Even when I take tablets I have less than 2 hours of sleep
- ❑ Pain prevents me from sleeping at all

Social Life

- ❑ My social life is normal and gives me extra pain
- ❑ My social life is normal but increases the degree of pain
- ❑ Pain has not significant effect on my social life aprt from limiting my more energetic interests, e.g. dancing
- ❑ Pain has restricted my socail life and I don't go out often
- ❑ **I have no social life because of pain**

Traveling

- ❑ I can travel anywhere without extra pain
- ❑ I can travel anywhere but it gives me extra pain
- ❑ Pain is bad and I manage journeys over 2 hours
- ❑ Pain is bad abut I manage journeys less than 1 hour
- ❑ Pain restricts me to short necessary journeys under 30 minutes
- ❑ **Pain prevents me from traveling except to the doctor or hospital**

Changing Degree of Pain

- ❑ My pain is rapidly getting better
- ❑ My pain fluctuates but overall is definitely getting better
- ❑ My pain seems to be getting better but improvement is slow at present
- ❑ My pain is neither getting better nor worse
- ❑ My pain is gradually getting worse
- ❑ My pain is rapidly getting work