Life Care Chiropractic & Wellness Center

Workman Compensation History Form

Patients Name _____ Date _____

Name of Compensation Carrier _____ Phone _____

Address of Carrier _____ City _____ State ____ Zip _____

Employers Name _____ Phone _____

Employers Address _____ City _____ State ____ Zip _____

1. Type of Business _____ Your Occupation _____
2. Date of Accident _____ Time _____ AM/PM
3. Was the accident reported to your employer? ☐ Yes ☐ No
   Name of person reported to _____
4. Are you off work now? ☐ Yes ☐ No Date last worked _____
5. Injured at: _____ City _____ State _____ Zip_____
6. Type of work being performed at time of injury _____
7. In your own words please describe the incident of injury: _____
   _____
8. Where did you go immediately following the accident? ☐ Home ☐ Hospital ☐ Work ☐ Other
   _____

Name of Hospital _____ City _____ State _____

Were you admitted to the hospital? _____ If so, date of release _____

What treatment was received? _____

9. Which of the following diagnostic tests were performed and at what facility:

☐ X-rays _____ ☐ MRI _____

☐ CT Scan _____ ☐ EEG_____

☐ Other _____

10. Have you seen another doctor for this accident? ☐ Yes ☐ No If yes, by whom?_____

What treatment was received? _____

For how long? _____

11. Are you: ☐ improving ☐ unchanged ☐ getting worse
12. List your current symptoms: _____
13. Which of these symptoms were you suffering from prior to your accident/ injury?
    _____
14. Have you ever been involved in any similar type of injury? ☐ Yes ☐ No
    If yes, describe _____

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Job Description

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

1. In a typical eight hour work day, I: (Circle # of hours/ activity)

Sit: ①②③④⑤⑥⑦⑧ hours
Stand: ①②③④⑤⑥⑦⑧ hours
Walk: ①②③④⑤⑥⑦⑧ hours

2. On the job I perform the following duties:

	Not at all	Occasionally	Frequently	Continuously
Bend/ Stoop	○	○	○	○
Squat	○	○	○	○
Crawl	○	○	○	○
Climb	○	○	○	○
Reach above shoulder level	○	○	○	○
Kneel	○	○	○	○
Balancing	○	○	○	○
Pushing/ Pulling	○	○	○	○

3. On the job, I lift:

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 your feet used for repetitive movements, such as operating foot controls? ☐ Yes ☐ No
6. Do you use your hands for repetitive actions, such as ☐ simple grasping ☐ firm grasping ☐ fine manipulating
7. Please list any additional comments you feel may be pertinent to your work situation:

_____

_____

PLEASE READ BEFORE SIGNING

I, _____ had an injury caused by a work related injury on (date)_____.
Until such time as my insurance is verified, I understand that I am fully responsible for charges for services rendered. I also understand that I am fully responsible for any services not covered by my insurance. I agree to participate in medical and therapy treatments and accept that no guarantee of results or outcome is expressed.

Signature_____ Date_____

Witness_____