WORKER'S COMPENSATION INFORMATION

PATIENT INFORMATION

First Name ________________________ MI ___ Last Name ____________________ Birthdate_________________

Home Address______________________________________ City_________________ State_____ Zip ________

Home Phone______________________ Cell Phone_______________________ Work Phone______________________

EMPLOYER INFORMATION

Employer Name____ Employer Phone____________________

Employer Address__________________________________ City____________________ State______ Zip ________

WORKER'S COMPENSATION INFORMATION

Worker's Compensation Insurance Carrier____

Carrier Address ____________________________________ City____________________ State_____ Zip__________

Carrier Phone Number __________________ Claim #____________________ Adjuster Name____________________

INJURY INFORMATION

Date of Injury___________________ Time of Injury_______ ☐AM ☐PM Place of Injury___________________________________

Injury reported to employer? ☐Yes ☐No Name of person you reported injury to____

Describe in detail how injury occurred:____

____

____

____

____

Have you lost time from work? ☐ Yes ☐ No If so, how much? ___________________________________

TREATMENT

Have you seen any other physician(s) regarding this injury? ☐Yes ☐No

If yes, please list name, address and phone ____

Were x-rays taken? ☐Yes ☐No Which views?: ☐Cervical ☐Thoracic ☐Lumbar ☐Other____________________

Were any other tests performed? ☐MRI ☐CT-Scan ☐Other_______________________

Name and location of facility where tests were performed____

What was the diagnosis? ____

What treatment was rendered? ____

____

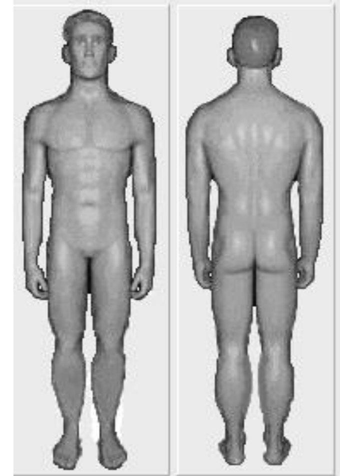
SYMPTOMS/INJURIES

If you have had any of the following symptoms since your injury, please ☑ check:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiffness
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Difficulty sleeping
☐ Dizziness	☐ Jaw problems	☐ Upset stomach/nausea
☐ Buzzing in ears	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Blurred vision
☐ Fatigue	☐ Constipation	☐ Diarrhea

Is this condition getting progressively worse? ☐Yes ☐No ☐Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling:



Rate the severity of your pain on a scale of 1(least pain) to 10(severe pain) ______

Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness
☐Shooting ☐Burning ☐Tingling ☐Cramps
☐Aching ☐Stiffness ☐Swelling ☐Other ____________

How often do you have this pain? ____

Is it constant or does it come and go? _____________________________________

Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation

Movements that are painful to perform: ☐Sitting ☐Standing ☐Walking
☐Bending ☐Lying Down

Is your pain worsened when: ☐Arising from a chair ☐Coughing ☐Sneezing ☐Changing positions in bed
☐ Stretching ☐ Twisting ☐Straining your bowels

Do any of the following relieve your pain?: ☐Ice pack ☐Heating pad ☐Hot bath/shower ☐Wearing a brace

Have you ever been injured in a similar manner? ☐Yes ☐No Dates of previous injuries_______________________

If yes, please explain: ____

____

What treatment was performed?____

By whom/where were you treated?____

AUTHORIZATION

I certify that a First Report of Injury has been completed with my employer for this work related injury and assign directly to Petersen Chiropractic Center all insurance benefits, if any, otherwise payable to me for services rendered. I clearly understand and agree that I am personally responsible for payment of all charges in the event that my claim for Worker Compensation benefits is denied. I understand that Petersen Chiropractic Center cannot bill my health insurance company for treatment received as a result of injuries sustained while working for my employer. I also understand that if the information necessary to submit claims on my behalf isn't provided, if claims are not paid within 30 days of submission or if I suspend or terminate my care in this office I will be required to immediately pay for any and all services rendered.

I authorize the use of my signature on all insurance submissions. I also authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits.

Patient Signature ____ Date______________________

Patient Name____ Date of Injury __________________________________

WORK DESCRIPTION & DUTIES

Please describe your job duties:____

____

____

In a typical 8 hour workday, how many hours do you: (☑ the appropriate number of hours for each)

Sit ▢0 ▢1 ▢2 ▢3 ▢4 ▢5 ▢6 ▢7 ▢8
Stand ▢0 ▢1 ▢2 ▢3 ▢4 ▢5 ▢6 ▢7 ▢8
Walk ▢0 ▢1 ▢2 ▢3 ▢4 ▢5 ▢6 ▢7 ▢8

Lifting ability **BEFORE** your injury:
How many pounds would/could you lift? Average __________ Maximum_________
How far could you carry this weight? ____________________ For how long a period of time?_____________________
How often would you carry this amount? _________________________
Lifting ability **AFTER** your injury (without experiencing pain, discomfort or restriction of motion):
How many pounds can you lift? __________________
How far can you carry this weight?______________________ For how long a period of time?_____________________
How often can you carry this weight?____________________________
What symptoms does lifting produce?____
How long do these symptoms last? ____________________
Did you experience these symptoms when lifting before your injury? ▢Yes ▢No

On the job, I perform the following activities: (mark all that apply with an "X")
In terms of an 8 hour workday *occasionally* means 0-33%, ***frequently*** means 34-66%, and ***continuously*** means 67-100%

	Not at all	Occasionally	Frequently	Continuously
Bend/Stoop				
Squat				
Crawl				
Climb				
Reach overhead				
Crouch				
Kneel				
Push/Pull				
Balance				

Relate your **BEFORE** injury capacity (mark '**B**') and your **AFTER** injury capacity (mark '**A**') when performing the following activities:

	Normal	Limited	Difficult	Painful
Walking				
Sitting				
Standing				
Bending				
Stooping				
Lifting				
Pushing				
Pulling				
Climbing				
Reaching				
Gripping				
Kneeling				
Balancing				

Patient Signature ____ Today's Date___________________