PIERSON FAMILY CHIROPRACTIC, P.C.
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WORKMEN'S COMPENSATION HISTORY FORM

Name_____ Date _____

Address _____

Home Phone _____ Cell Phone _____

Date of Birth _____

Employer's Name _____

Address _____

Phone _____

Occupation _____

Describe your job _____

_____

Insurance Company _____

Address _____

Phone _____

Policy No. _____

Claim No. _____

NATURE OF ACCIDENT

Date of Accident _____

In your own words, please describe how this injury occurred:

(Please be specific, use back of document if needed).

_____

_____

_____

_____

When did the pain begin? _____

Where on your body did you first experience pain? _____

_____

Was the pain: ___Intense or____Gradually came on afterwards?

Did you go the Hospital? _____Yes _____No

Name of Hospital? _____

Indicate any actions taken by yourself immediately following the accident:

____Went home and took it easy

____Went about normal business

____Went to a physician

____Went to Hospital

____You doctored yourself thinking the pain would go away

(Over the counter products)

____Pain began later that day

____Pain began later that night

____Pain began the next day

Were you treated by another doctor for **this** accident?

____Yes ____No

If yes, please give name and address: _____

_____

_____

What type of treatment did you receive? _____

_____

Have you had physical therapy? ____ Yes _____No

If yes, what type of treatment did you receive and how often? _____

_____

_____

On what date did you report this injury? _____

You reported this injury to? _____

What is the above person's job position? _____

Have you lost any time from work as a result of this new injury?

_____Yes _____No

If yes, please give dates: _____

Have you returned to work since this accident? _____Yes _____No

If you have gone back to work please list the work activities that are

a. Painful: _____

b. Difficult: _____

Please list any activities of daily living that you find painful or difficult:

_____ _____

_____ _____

Relative to where you were before this injury, how would you rate your recovery so far? _____%

Have you had any previous similar injuries? _____Yes _____No

a. If yes, Please give dates and describe injury:

_____

_____

b. When were you last treated for this previous injury?

_____

What are your **Present** physical complaints?

a. _____

b. _____

c. _____

d. _____

Are you: _____Improved _____Unchanged _____Getting worse?

On a scale of 0-10, with 0 being (examiner's quote) "You're pain free and can function well", and 10 being, "you're in pain all the time and cannot function at all". Where would you rate yourself? (Please **circle** one)

Normal	Low Pain	Moderate Pain	Intense Pain	Emergency
0	1 2 3	4 5 6	7 8 9	10

Please explain why:

_____

_____

Please list any additional comments:

_____

_____

_____

_____

_____

Signature:_____ Date_____

Doctors Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Doctors Signature: _____Date_____