WORK COMP HISTORY

Patient _____ Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birth Date _____ 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? ( )Y ( )N
3. Previous Workers' Compensation Injury? ( ) Y ( ) N
4. Accident reported to employer? ( ) Y ( ) N Name of person reported 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 the accident: _____

_____

_____

9. Have you been treated by another doctor for this accident? ( ) Y ( ) N
   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? _____

_____

12. Have you had physical therapy? ( )Y ( ) N If yes, how often
    ( ) Daily ( ) Every other day ( ) Several times a week ( ) Weekly ( ) Every other week
    ( ) Monthly ( ) Other
    Does the physical therapy help? ( ) Y ( ) N ( ) Don't know

13. Prior to this accident, have you ever had any of the physical complaints similar to what you have now? ( ) Y ( ) N ( ) Don't know
    If yes, describe: _____

    _____

    _____

    Were these similar complaints the results of a previous accident? ( ) Y ( ) N
    Please provide details of accidents: _____

    _____

    _____

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% 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	( )	( )	( )	( )

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 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	

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
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 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: _____

FOCUS CHIROPRACTIC CENTER

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San Fernando, Ca 91340
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916 West Burbank Blvd #L
Burbank, Ca 91506
(818) 842-7700 Fax (818) 842-7001

PATIENT'S NAME: _____ **TODAY'S DATE:** _____

YOUR MEDICAL HISTORY

Do you suffer from?

High Blood Pressure	_____	Diabetes	_____
Arthritis	_____	Tuberculosis	_____
Ulcers	_____	Kidney/Liver Disease	_____
Epilepsy	_____	Heart Disease	_____

Others _____

_____

Previous Surgeries or Hospitalizations: _____

_____

ALLERGIES (Please include all to drugs/food/etc.) _____

PREVIOUS WORK OR/AND CAR ACCIDENTS IN THE PAST 10 YEARS:

_____

_____

YOUR HABITS

Do You: Drink Coffee _____ Drink Alcohol _____ Use Tobacco _____ Use Illicit Drugs _____

How much of each? _____ _____ _____ _____

Do You: Use any prescribed medication? ____ Names: _____

Did/Do You: Take any medication **after** this accident? ___ Names: _____

Do you Exercise Regularly? Yes / No How Often? _____

Have you stopped your exercise habits since the accident? _____

FAMILY HEALTH PROBLEMS (please, only major medical illnesses such as diabetes, cancer, HBP, etc.)

Mother's Health History: _____

Father's Health History: _____

Other Blood Relative: _____

YOU ARE: MARRIED SINGLE **YOU HAVE: CHILD(REN)**