STEELE CHIROPRACTIC

Workers Compensation Intake Form

Patient Information:

Today's Date_____
Name:_____
Address: _____
_____
Sex **MALE** **FEMALE**
Occupation:_____
Employer:_____
Address: _____
_____

Primary Phone:_____
Secondary Phone:_____
Social Security #:_____
Date of Birth:_____
Marital Status:_____
Have you ever been to a chiropractor before?
YES NO

Accident Information:

Date of accident:_____ Time of accident:_____
Did you report the accident to your employer: NO YES (name of person notified)_____
Briefly describe the accident:_____
_____
_____

Workers Compensation Insurance Information:

Employer Name:_____ Phone:_____
Workers Compensation Insurance Company:_____
Adjustor Name:_____ Phone:_____
Claim #:_____

Job Related Information:

Have you missed any work since the accident: **NO** **YES** (dates)_____
Has this condition restricted your work? **NO** **YES** (how)_____
How many hours are in your normal work day? _____
Please circle your daily job duties and activities you are asked to perform:

STANDING	**OPERATING EQUIPMENT**	**DRIVING**	**SITTING**
TWISTING	**WORK W/ARMS ABOVE HEAD**	**WALKING**	**CRAWLING**
TYPING	**LIFTING**	**BENDING**	**STOOPING**

Post Accident Information:

Rate your pain **today** on a scale of 1-10 (1 being no pain and 10 being unbearable)_____

Please describe your **pain(s)**(burning, sharp, tight etc) and **location(s)** :_____

_____

_____

Have you experienced pain in this location(s) before? **NO** **YES** (when)_____

When did these symptoms begin? **IMMEDIATLEY** **LATER, SAME DAY** **DIFFERENT DAY**

Since the accident has your condition: **IMPROVED** **WORSENED** **STAYED SAME**

Does anything make your condition improve? **NO** **YES** _____

Does anything make your condition worse? **NO** **YES**_____

Have you seen any other doctor(s) since the accident: **NO** **YES** (name)_____

Did you require hospitalization: **NO** **YES** (name)_____

Did you have an X-ray, MRI or any other tests for this condition? **NO** **YES** (describe)_____

Health History:

Please list all medications you are currently taking for this or any health condition (including vitamins):

_____

_____

Please list any allergies (including medications, environmental, food): _____

_____

Please list **any** medical conditions that you **currently have or have had** (cancer, diabetes, high blood pressure, dizziness etc):_____

_____

_____

Please list **any** surgeries you have had from **birth-present**:_____

_____

_____

Do you smoke? **NO** **YES** (how much)_____ (for how long)_____

Former Smoker, but quit Years since last smoked_____

For Women: Are you currently taking birth control? **NO** **YES** (name)_____

Are you pregnant? **NO** **YES** due date_____/_____/_____

Patient Signature_____ Date_____