ELEVATE
CHIROPRACTIC

Worker's Compensation History

Patient Name:_____ S.S.#:_____
Address:_____ City:_____ State:_____ Zip:_____
Birthday:_____ Sex:_____ Martial Status:_____ Spouse's Name_____
Home #: _____ Cell #_____ Work #_____
Email:_____ Occupation:_____
Emergency Contact:_____ Relationship:_____ Phone #:_____
How were you referred to our office?_____

Employer's Name:_____ Phone #:_____
Address:_____ City:_____ State:____ Zip:_____
Carrier's Name:_____ Phone #:_____
Claim #:_____ Adjuster's Name:_____
Address:_____ City:_____ State:_____ Zip:_____
Have you retained legal counsel for this injury? Y/N If yes, give name and address:_____
_____

Injury Description

Date of present injury:_____ Time of injury:_____ AM/PM Overtime Y/N
Who saw the accident? Name:_____ Title:_____
Who reported the accident? Name:_____ Title:_____
What medical attention was rendered?_____
By whom? Nurse_____ MD_____ DO_____ DC_____ Other employee_____ Other_____
How did the injury occur?_____
Chief Complaint:_____ Symptoms:_____
Since the injury, are your symptoms_____ improving, _____ the same, _____ or getting worse?
If working on a machine, give description:_____

Movements on the Job

Do you move to your _____ right, _____ left, _____ up, _____ down, _____ under,_____ or over?
Do you use foot or hand levelers? Y/N Do you work overhead? Y/N
Do you have to reach? Y/N Where?_____
Do you pick up or lift? Y/N If yes, how much?_____ how often?_____
From where to where?_____ Do you lift from the ___ground, _____bench,____platform,
____box, _____ pallet, _____or other? If other, describe:_____
Do you lift in or out of a machine? Y/N If working at a machine, do you ____sit,___ stand, ___ or kneel?
Is your work area cluttered? Y/N If yes, give specifics:_____
Total amount of weight being pushed or pulled on a daily basis:_____

Office Work

(If your injury occurred from office work only, please fill out the following)

Do you ____ sit at a desk, ____ walk, _____, stand, _____ hold, _____ carry, _____ or other?
Give percentage if applicable of how often you do the following above:_____
Do you operate office machinery? Y/N If yes, what type?_____
If your work is at a desk, give specifics of the job (computer, business machines, phone, etc…):_____
Do you carry anything or pick anything up? Y/N If yes, what?_____

Previous Work History

Was a pre-employment exam preformed or required? Y/N
If yes, Date:_____ Doctor:_____ Place:_____
Have you ever applied for Worker's Compensation benefits before? Y/N Date:_____
Reason:_____
Was there a time loss from work? Y/N From _____ to _____ year_____
Did you retain legal counsel for these injuries? Y/N If yes, give name and address:_____
_____

Present Work History

What is the job classification of your normal job?_____
Were your performing your normal job when you had your injury? Y/N
What shift were you working?_____ How long have you been working at your job?_____
Has there been a time loss or absenteeism caused from the injury? Y/N If yes, explain_____
_____

Job Conditions

Type of floor:____ rough ____ smooth____ wood____ concrete____ steel____ other If other, _____
Type of lighting: _____ fluorescent ____ overhead _____on machine _____ other If other, _____
Are you tired when you go home at night? Y/N Do you have any outside jobs? Y/N If yes, describe_____
_____
How many employees work in the work place?_____ How many employees per shift?_____
How many employees do your job?_____ What is the current injury ratio at your job?_____
How many employees have been injured doing your job? _____ Do you like your job? _____

I hereby authorize this office and its doctors to administer care to myself as they deem necessary.

Signature:_____ Date: _____