WORKERS COMP

DR. USE ONLY
H.R.:_____
B.P.:___/_ _ ___
Weight:___ _____

BONT CHIROPRACTIC

File#:_____
Date:_____

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

Employer's Name:_____ Tel. #:_____
Address:_____ City:_____ State:_____ Zip:_____
Carrier's Name:_____ Tel. #:_____
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? _____
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/hand levelers? Y/N Do you work overhead? Y/N Do you have to reach? Y/N
Do you pick up or lift? Y/N If yes, how much?_____ how often?_____
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
Total amount of weight being pushed or pulled on a daily basis: _____

Office Work:
Do you? sit at a desk, _____ walk, _____ stand, _____ stoop, _____ hold, _____ carry, _____ or other?
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? _____
What is the job classification of your normal job?_____
Were you 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_____
_____
Average hours worked a week? _____ Worked a day?_____ How many days a week do you work? _____

Please Describe your injuries and Symptoms resulting from this accident:_____

_____

_____

_____

_____

_____

What medication(s) did you take?_____

_____

Are you still taking medication? Yes ☐ No ☐

If yes, how often & how much_____

_____

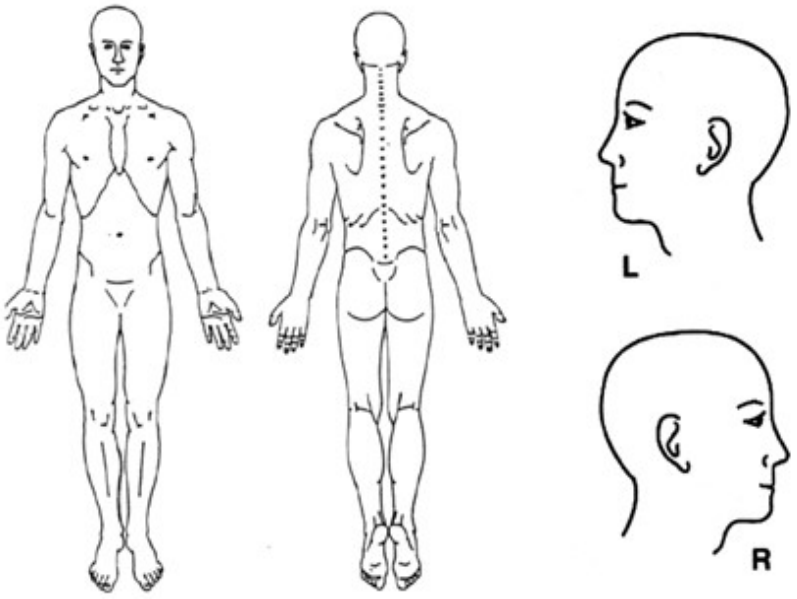
Did you return to work? Yes ☐ No ☐

If no, how long were you off? _____

If yes, were there any restrictions or limitations?

_____

_____



Please mark the degree of all conditions which you have, or have had. Use the following letters to rate your conditions

O = Occasional
F = Frequent
C = Constant

GASTRO-INTESTIONAL
_____Nausea
_____Vomiting Food
_____Vomiting Blood
_____Abdominal Pain
_____Poor Appetite
_____Excessive Hunger
_____Difficult Chewing
_____Difficult Swallowing
_____Excessive Thirst
_____Diarrhea
_____Constipation
_____Bloody Stool
_____Black Stool
_____Hemorrhoids
_____Weight Trouble
_____Liver Trouble
_____Gallbladder Trouble

NERVOUS SYSTEM
_____Dizziness
_____Fainting
_____Numbness
_____Loss of Feeling
_____Paralysis
_____Headaches
_____Convulsions
_____Muscle Spasms
_____Forgetfulness
_____Confusion
_____Depression

CARDIO-VASCULAR
_____Chest Pain
_____Rapid Heartbeat
_____Heart Problems
_____Pain over Heart
_____BP Problems
_____Varicose Veins
_____Coughing Phlegm
_____Coughing Blood
_____Persistent Cough
_____DIfficult Breathing

EYE, EAR, NOSE & THROAT
_____Eye Strain
_____Vision Problems
_____Eye Infections
_____Hearing loss
_____Ear Noises
_____Ear Pain
_____Ear Discharge
_____Nose Bleeding
_____Nose Discharge
_____Nose Pain
_____Difficult Nose Breathing
_____Difficult Speech
_____Dental Problems
_____Sore Gums
_____Sore Mouth
_____Sore Throat
_____Hoarseness

GENITO-URINARY
_____Bladder Trouble
_____Painful Urination
_____Discolored Urine
_____Excessive Urination

FEMALE
_____Vaginal Discharge
_____Vaginal Bleeding
_____Vaginal Pain
_____Breast Pain
_____Lumps on Breast

Are you pregnant?
☐ YES ☐ NO

MUSCULO-SKELETAL
_____Low back Problem
_____Neck Problems
_____Pain on shoulders
_____Arm Problems
_____Leg Problems
_____Painful Joints
_____Stiff Joints
_____Swollen Joints
_____Sore Muscles
_____Weak Muscles
_____Broken bones
_____Ruptures
_____Walking problems

I HEARBY AUTHORIZE THIS OFFICE AND ITS DOCTORS TO ADMINISTER CARE TO MYSELF AS THEY DEEM NECESSARY

_____ _____

PATIENT SIGNATURE DATE