ADVANCED PHYSICAL MEDICINE

WORK RELATED ACCIDENT

Physical Therapy • Chiropractic • Rehab

ABOUT YOU

Today's Date _____ File # _____

Patient Name _____
(Last) (First) (MI)

ADDITIONAL INSURANCE

Type of Insurance _____

Co. Name _____

Address _____

Phone _____

Insured's name _____

Policy # _____ Claim # _____

Insured's SS # _____ D.O.B. _____

Insured's Employer _____

Agent's Name _____

ACCIDENT INFORMATION

Date & time of accident _____ ○ a.m. ○ p.m.

Was your accident directly related to work? ○ Yes ○ No

Briefly describe the events before and during your accident

_____

_____

_____

Address accident occurred (if other than your employer's address)

_____

_____

Was anyone else present during your accident? ○ Yes ○ No

Did you report your accident to your employer? ○ Yes ○ No

What recommendations did you employer make just after the accident?

_____

_____

Has this type of accident happened to you before? ○ Yes ○ No

To the best of your knowledge, has this accident occurred at your workplace before? ○ Yes ○ No

In general

Is your job physically stressful? ○ Yes ○ No

Is your job mentally stressful? ○ Yes ○ No

Is your workplace noisy? ○ Yes ○ No

Have you changed jobs in the last year? ○ Yes ○ No

CONTINUE ON BACK

AFTER INJURY

Did the accident render you unconscious ○ Yes ○ No

If yes, how long? _____

Please describe how you felt immediately after the accident _____

_____

Have you gone to the hospital or seen any other Doctors? ○ Yes ○ No

When did you go? ○ Just after accident ○ Next day ○ 2 days plus

How did you get there? ○ Ambulance ○ Private transportation

Name of Hospital and/or attending Doctor _____

Was he/she a ○ D.C ○ M.D. ○ D.O. ○ D.D.S.

Describe any treatment you received _____

_____

Were X-rays taken? ○ Yes ○ No

Was medication prescribed? ○ Yes ○ No

Have you been able to work since this injury? ○ Yes ○ No

Are your work activities restricted as a result of this injury? ○ Yes ○ No

Have you retained an attorney? ○ Yes ○ No

If yes, whom _____

Their Phone _____

Indicate the symptoms that are a result of this accident

○ Dizziness	○ Chest Pain	○ Jaw problems	○ Nausea
○ Memory Loss	○ Irritably	○ Arms/shoulder pain	○ Back pain
○ Headache(s)	○ Fatigue	○ Numb hands/fingers	○ Lower back pain
○ Blurred Vision	○ Tension	○ Difficulty Sleeping	○ Back stiffness
○ Buzzing in ear	○ Neck Pain	○ Shortness of breath	○ Leg pain
○ Ears ringing	○ Neck Stiff	○ Stomach upset	○ Numb feet/toes

Indicate your degree of comfort while performing these activities

	Comfortable	Uncomfortable	Painful
Lying on back	○	○	○
Lying on side	○	○	○
Lying on stomach	○	○	○
Sitting	○	○	○
Standing	○	○	○
Stretching	○	○	○
Lovemaking	○	○	○
Walking	○	○	○
Running	○	○	○
Sports	○	○	○
Working	○	○	○
Lifting	○	○	○
Bending	○	○	○
Kneeling	○	○	○
Pulling	○	○	○
Reaching	○	○	○

Is your condition getting worse? ○ Yes ○ No ○ Constant ○ Comes & goes

RECOVERY

How many hours in a normal work day _____

Please indicate your daily job duties and any activities which you are occasionally asked to perform

○ Standing	○ Driving	○ Operating equipment
○ Sitting	○ Twisting	○ Work with arms above head
○ Walking	○ Crawling	○ Typing
○ Lifting	○ Bending	○ Stooping

○ Other _____

What positions can you work with minimal physical effort? How long?

_____

Prior to the injury were you capable of working on an equal basis with others of your age? ○ Yes ○ No ○ N/A Do you work with others who can help with heavy lifting? ○ Yes ○ No ○ N/A While in recovery, is there light duty work you could request? ○ Yes ○ No ○ N/A

If any of your medical or account information has changed, please inform our front desk personnel. Please remember that you are ultimately responsible for your account.

Signature _____

Date _____

For office use only

_____

_____

_____

_____

_____

_____

_____