CRESCO CHIROPRACTIC CLINIC P.C.
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Work Accident History

Dear Patient: We need this information because we care enough to want to know, and your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Patient Information **Acct#**_____

_____
Last Name First Name Middle Initial Nick Name

Occupation (specific job title)_____

Emergency Contact Information:_____Phone#_____

Employer Information

_____
Company Name Supervisor Name Phone #

_____
Address City State Zip Code

_____
Nature of business (eg. Food manufacturing, building construction, clothing retailer, etc.)

Insurance Information

If you have any insurance information please give it to the staff person assisting you

Accident/Injury History

1. Date of Accident/Injury:_____ ( ) Gradual ( ) Sudden ( ) Progressive
2. Address/location where you were injured (please include City and County):_____
   _____
3. Time of day accident occurred:_____am/pm Date last worked:_____
4. Did you report this to your employer? ( ) Yes ( ) No If so, to whom?_____
5. Did you go to the hospital or another doctor's office after the accident? ( ) Yes ( ) No
6. Describe how the accident/injury occurred:_____
   _____
   _____
7. What is your **number one** problem or the **one area** of greatest pain?_____
   _____
8. Have you ever experienced this problem before? ( ) Yes ( ) No If so, when?_____
9. Please rate the level of this pain on the following scale: **0 is no pain at all, 10 is severe pain** or the worst pain you have ever felt. If your pain varies from day to day please circle two numbers to indicate the range of your pain. **0 1 2 3 4 5 6 7 8 9 10**
10. How often do you experience the pain?
    ___1-2 hours per day ___About half of the day ___Most of the day
    ___The pain never goes away ___Other, briefly explain_____

11. How does the pain affect your daily activites?

___It does not affect my daily activites ___I have had to change how I do things

___I have to stop doing some of my daily activites ___I am unable to perform daily activites

12. What **increases** your pain?_____

13. What **decreases** your pain?_____

14. List any other complaints currently bother you and rate your pain level for each.

a. _____ **0 1 2 3 4 5 6 7 8 9 10**

b. _____ **0 1 2 3 4 5 6 7 8 9 10**

c. _____ **0 1 2 3 4 5 6 7 8 9 10**

d. _____ **0 1 2 3 4 5 6 7 8 9 10**

15. Do you feel you could perform your usual job right now? ( ) Yes ( ) No

16. Describe your usual routine job duties:_____

_____

_____

17. If you are working, how has your current condition affected your normal duties?_____

_____

_____

18. Is there any activity or duty you are unable to perform?_____

_____

19. How often does your job require you to do the following:

___Lifting	(___lbs)
___Sitting	(___hrs/day)
___Standing	(___hrs/day)
___Computer	(___hrs/day)
___Telephone	(___hrs/day)
___Driving	(___hrs/day)
___Push/pull	(___Once in a while ___Often ___Frequently ___Almost all the time)
___Reach overhead	(___Once in a while ___Often ___Frequently ___Almost all the time)
___Grasping	(___Once in a while ___Often ___Frequently ___Almost all the time)
___Twisting/bending	(___Once in a while ___Often ___Frequently ___Almost all the time)
___Squatting/kneeling	(___Once in a while ___Often ___Frequently ___Almost all the time)
___Walking	(___Once in a while ___Often ___Frequently ___Almost all the time)
___Climbing/ladders	(___Once in a while ___Often ___Frequently ___Almost all the time)
___Oher	Explain:_____

20. Have you ever been injured at work **prior to** this accident/injury? ( ) Yes ( ) No If so, when?_____

Explain:_____

21. Have you ever been in an automobile accident before? ( ) Yes ( ) No If so, when?_____

Were you injured? ( ) Yes ( ) No Explain:_____

22. List all surgeries you have had (with date):_____

_____

23. List all medications you are currently taking (prescribed and over the counter):_____

_____

24. Please add anything else you would like the doctor to know:_____

_____

_____

If you have experienced any of the following conditions in the **past** mark a "**P**" on the line provided. If you are **currently** experiencing any of the following conditions please mark a "**C**" on the line provided. (please mark all that apply)

___heart attack
___diabetes
___difficulty with urination
___prostate problems
___AIDS
___dizziness
___constipation
___nausea
___ears ringing
___Gout
___knee/hip replacement
___Stroke
___Glaucoma
___Diverticulosis
___Anemia
___ulcers
___loss of memory
___diarrhea
___muscle cramping
___headache
___tuberculosis
___broken bones (specifiy below)
___Arthritis
___fainting spells
___difficulty with bowel movements
___Cancer
___Epilepsy
___sprained ankle ( ) R ( ) L
___chest pain
___general fatigue
___soreness in joints
___Migraine
___Syphilis
___gallbladder problems
___kidney stones
___Asthma
___menstrual cramping
___shortness of breath
___sudden weight loss
___loss of hearing
___bloody stools

Please list any other conditions or specify above conditions here:_____
_____
_____

General Activities (check all that apply)

___sleep on waterbed
___sleep in stomach
___sewing
___exercise _____x/wk
___computer/TV/video game___hr/day
___needlepoint/knitting
___lift weights_____x/wk
___jog/run_____x/wk
___use cardio equip._____hrs/wk
___use two or more pillows
___reading in bed
___swimming_____hrs/wk

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Cresco Chiropractic Clinic P.C. to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payer and/or health practitioners. I authorize and request my insurance company to pay directly to Cresco Chiropractic Clinic P.C. benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf of my dependents.

Patient's
signature_____Date_____
(signature of parent or legal guardian if patient is a minor)

Doctor's
Comments:_____
_____
_____