SPINE CARE NETWORK
CHIROPRACTIC SERVICES

WORK RELATED ACCIDENT

Date & Time of Accident: _____ ❑ a.m. ❑ p.m.
Was your accident directly related to your work?
❑ Yes ❑ No
Briefly describe the events that occurred just before and during your accident: _____

_____

_____

Give the address where accident occurred: (if other than 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 your employer make just after your accident? _____

_____

Has this type of accident happened to you before?
❑ Yes ❑ No
To the best of your knowledge, has this accident occurred in 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

ADDITIONAL INSURANCE

2nd Insurance Source or Auto 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: _____

AFTER INJUR Y

Did accident render you unconscious? ..... ❑ Yes ❑ No
If yes, for how long? _____
Please describe how you felt immediately after the accident:

_____

_____

Have you gone to a Hospital or seen any other Doctor? ❑ Yes ❑ No
When did you go? ❑ Just after accident ❑ The next day ❑ 2 days plus
How did you get there? ❑ Ambulance or ❑ 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
Indicate ☑ the symptoms that are a result of this accident:

❑ Dizziness	❑ Difficulty sleeping	❑ Jaw problems	❑ Nausea
❑ Memory loss	❑ Irritability	❑ Arms/Shoulder pain	❑ Back pain
❑ Headache(s)	❑ Fatigue	❑ Numb Hands/Fingers	❑ Lower back pain
❑ Blurred vision	❑ Tension	❑ Chest pain	❑ Back stiffness
❑ Buzzing in ear	❑ Neck pain	❑ Shortness of breath	❑ Leg pain
❑ Ears ringing	❑ Neck stiff	❑ Stomach upset	❑ Numb Feet/Toes

❑ Other _____
Is your condition getting worse?
❑ Yes ❑ No ❑ Constant ❑ Comes & goes
Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful (even if only sometimes)
Lying on back	❑	❑	❑
Lying on side	❑	❑	❑
Lying on stomach	❑	❑	❑
Sitting	❑	❑	❑
Standing	❑	❑	❑
Stretching	❑	❑	❑
Lovemaking	❑	❑	❑
Walking	❑	❑	❑
Running	❑	❑	❑
Sports	❑	❑	❑
Working	❑	❑	❑
Lifting	❑	❑	❑
Bending	❑	❑	❑
Kneeling	❑	❑	❑
Pulling	❑	❑	❑
Reaching	❑	❑	❑

Have you retained an attorney: ❑ Yes ❑ No
If yes, whom: _____
His/Her Phone #: _____