Cuttler
CHIROPRACTIC

WORKERS' COMPENSATION HISTORY

Name _____ Date _____

Date of Accident_____ Time of Accident_____ AM / PM Are you presently working? Y / N

Name of Employer at time of accident _____ Did you file an accident report? Y / N

Employer Address _____

City _____ State_____ Zip _____ Phone # ( )_____

Job Duties _____

In your own words, please describe how the accident _____

_____

_____

What hurt after the accident? _____

_____

_____

Prior to this accident did you have any of the above complaints? _____

_____

_____

Did you receive medical attention at the scene of the accident? _____

Where did you go immediately following the accident? A) Hospital B) Home C) Personal Doctor D) To this office E) Resumed

Have you been x-rayed for this problem? Y / N If you have seen another doctor, what is his or her name? _____

In terms of an 8 hour workday I : (Circle number of hours of each activity)

Sit (1 2 3 4 5 6 7 8) hours
Stand (1 2 3 4 5 6 7 8) hours
Walk (1 2 3 4 5 6 7 8) hours

On the job, I perform the following acitivities: (Circle as many as

A) Bend/Stoop B) Squat C) Crawl D) Climb E) Reach above shoulders F) Crouch G) Kneel H) Push/Pull I) Maintain awkward posture

On the job, I regularly lift between:

A) 1-10 lbs. B) 11-24 lbs. C) 25-34 lbs. D) 35-50 lbs. E) 51-74 lbs. F) 75-100 lbs.

Are you required to bend over while lifting? Y / N Are there jobs which do not require bending and lifting? _____

Office Use Only

Employer's Worker's Compensation Insurance Carrier _____

Address _____

_____

Phone# _____

Doctor's Use

Disabled Y / N Disability Level T or P Unable to work from / / to / /

Factors delaying recovery _____

_____

Remarks (resume limited / regular work date / limitations) _____

_____

Diagnosis # _____ Status A or C Area of involvement _____

Last x-ray date _____ Treatment Plan _____

_____

_____