LEMONT ACTIVE CHIRO

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WORKERS COMPENSATION PATIENT INTAKE FORM

Name _____ Today's Date _____

EMPLOYER
Employer Name_____ Employer Phone_____
Employer Address_____ City_____ State_____ Zip_____
Contact Person _____ Email address _____

WORKERS COMPENSATION CARRIER
Workers Comp. Carrier_____ Adjuster's Name_____
Carrier Address_____ City_____ State____ Zip_____
Claim Number _____ Carrier Phone_____

ATTORNEY INFORMATION (If Applicable)
Attorney Name_____ Attorney Phone_____
Attorney Address_____ City_____ State____ Zip_____
Contact_____ **File Number** _____

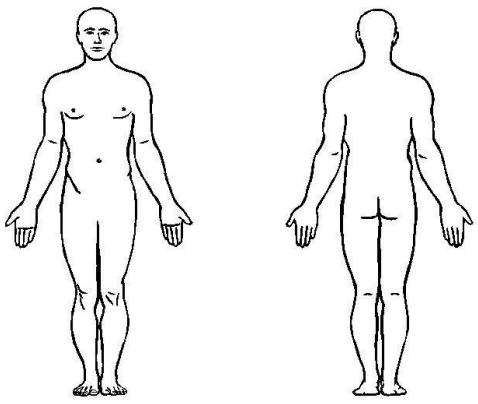
HISTORY OF COMPLAINT
What are your symptoms due to this work injury?
□ Neck Pain □ Radiate L or R arm? □ Headache
□ Low Back Pain □ Radiate L or R leg? □ Mid-back Pain
□ Other (specify) _____
Dr. Notes:_____
_____

Describe symptoms:
1. □ pain □ numbness □ tingling □ stiffness □ burning □ dull □ sharp □ aching
   □ throbbing □ other_____
2. □ worsening □ improving □ unchanged
3. □ constant □ frequent □ intermittent □ occasional

Dr. Notes: _____
_____

List and circle the intensity of your symptoms:
(0 = none, 10 = most severe)
Body part _____0-1-2-3-4-5-6-7-8-9-10
Body part _____0-1-2-3-4-5-6-7-8-9-10
Body part _____0-1-2-3-4-5-6-7-8-9-10
Body part _____0-1-2-3-4-5-6-7-8-9-10

Mark the areas where your symptoms occur:



When did your symptoms begin?
Month_____ Day_____ Year _____
Dr. Notes:_____

How did your symptoms begin? □ suddenly □ gradually □ unknown
Dr. Notes: _____

When are your symptoms worse? □ morning □ afternoon □ evening □ unaffected by time

Does it interfere with: □ everything □ work □ sleep □ daily routine □ recreation
□ social □ other: _____

Have you noticed a change in: bowel function □ yes □ no
bladder function □ yes □ no
Describe: _____

What makes your condition better? □ nothing □ rest □ sitting □ standing □ stretching
□ exercise □ ice □ heat □ massage □ chiropractic □ medications □ other _____
Dr. Notes: _____

What makes your condition worse? □ nothing □ bending □ lifting □ coughing □ sneezing
□ walking □ sitting □ standing □ lying down □ changing positions □ turning □ reaching
□ driving □ straining □ other_____
Dr. Notes: _____

WORKERS COMPENSATION MECHANISM OF INJURY FORM

Date of Injury ____/____/____ Time _____ AM/PM Place of Injury _____
Accident reported to employer? □ yes □ no Name of person reported to _____
Give full description of how accident happened. _____
_____
_____
_____
Have you lost time from work because of this accident? □ yes □ no How much? _____
Other doctors seen for this condition: Name _____
Diagnosis _____
What treatments were given? (check all that apply) □ none □ x-rays □ pain medication
□ cervical collar □ stitches □ bandaged □ muscle relaxants □ physical therapy
□ instructed regarding concussion □ instructed regarding sprains/strains
□ instructed to call orthopedist □ instructed to call physician □ referred to this office
□ other _____
Have you had any previous Workers Compensation injuries? □ yes □ no Date: _____
Describe previous injuries: _____
Have you ever received Chiropractic care? □ yes □ no Approx. date of last visit _____
Name of Chiropractor _____ What were you treated for? _____

DUTIES UNDER DURESS SUMMARY

What is your job description? _____
_____
Check all activities that you have difficulty with at work. □ lifting □ bending □ sitting
□ standing □ walking □ computer duties □ other _____
Dr. Notes: _____
_____