Healthy Back Chiropractic

1707 Lansing Ave. NE Salem, OR 97305 phone: (503) 589-0700 fax: (503) 586-0255

WORK ACCIDENT INFORMATION

Patient Name _____ Date of Birth _____

Is this visit related to a **work accident**? □ Yes □ No

Date of Accident: _____ Claim #: _____

MCO Name _____ Attorney Name _____

Please describe in detail the accident. _____

_____

_____

_____

1. Where are, and what is the nature of your injuries? _____

   _____

   _____

2. Were you injured in an auto-accident at work? □ Yes □ No
3. Have you had this type of complaint before? □ Yes □ No When? _____
4. What is your usual job? _____
5. What were you doing when you were injured? _____

   _____

6. Are there job tasks you cannot perform now? □ Yes □ No What are they? _____

   _____

7. Have you discussed this injury with your employer? □ Yes □ No
8. Is there modified or alternative work at your job? □ Yes □ No
9. Have you lost wages or not been able to work due to the accident? □ Yes □ No
10. What has helped you feel better? _____
11. What has made if feel worse? _____
12. Have you had one or more of the following symptoms since your accident?

    □ Cannot sleep due to the accident □ having trouble getting to sleep since the accident
    □ Lost time from work due to the accident □ Have been depressed since the accident occurred

13. Have you been treated for injuries related to the accident already? □ Yes □ No

    If yes, by whom? _____

    Did they perform any diagnostic testing? □ Yes □ No