WORKERS COMPENSATION HISTORY

PATIENT NAME ____ PHONE NUMBER _________________________

ADDRESS _______________________________ CITY _________________ STATE ______ ZIP CODE ____________

AGE _________ BIRTHDATE ___________________ ( ) MALE ( ) FEMALE SSN _______________________

NAME OF COMPENSATION CARRIER (*if known*) _____________________________________ PHONE __________________

EMPLOYER'S NAME ____ PHONE ___________________________

EMPLOYER'S ADDRESS ________________________________ CITY __________________ STATE ____ ZIP __________

TYPE OF BUSINESS _______________________________ YOUR POSITION / TITLE ______________________________

DATE OF INJURY ___________________ TIME INJURY OCCURRED _________ AM/PM

LAST DATE WORKED ________________ ARE YOU CURRENTLY OFF WORK? Y N

HAVE YOU PREVIOUSLY SUFFERED AN INJURY THAT HAS BEEN COVERED BY WORKERS' COMPENSATION? Y N

WAS THE ACCIDENT REPORTED TO YOUR EMPLOYER? Y N

NAME OF SUPERVISOR REPORTED TO ____________________________

INJURED AT_______________________________ CITY__________________________ STATE_____ ZIP____________

HOW LONG HAVE YOU WORKED THERE PRIOR TO ACCIDENT?____

TYPE OF WORK BEING DONE AT THE TIME OF INJURY? ____

IN YOUR OWN WORDS, PLEASE DESCRIBE THE ACCIDENT/INJURY ____

____

____

HAVE YOU BEEN TREATED BY ANOTHER DOCTOR FOR THIS INJURY/ACCIDENT? Y N

WHAT TYPE OF TREATMENT DID YOU RECEIVE? ____

HOW LONG WERE YOU TREATED BY THIS DOCTOR? ____

ARE YOU: ( ) IMPROVED ( )UNCHANGED ( ) GETTING WORSE

What type of medication are you taking (*if any*)? ____

____

Have these medications helped? ( ) Yes ( ) No ( ) Not Sure Yet

Have you had physical therapy? ( ) Yes ( ) No If *YES*, how often?____________________________

Does the physical therapy help? ( ) Yes ( ) No ( ) Not Sure Yet

Prior to this accident, have you ever had any of the physical complaints similar to what you have now?

( ) Yes ( ) No ( ) Don't Know If *YES*, describe____

Were these complaints the result of a prior accident(s)? Y N

If *YES*, describe the details of the accident(s) ____

____

____

CURRENT MEDICAL COMPLAINTS

NECK PAIN:

My neck pain began: ( ) Gradually ( ) Suddenly

I have pain: ( ) Sometimes ( ) All of the time

May pain goes into my: ( ) Right arm ( ) Left arm ( ) Both

I have tingling and/or numbness in my: ( ) Right arm ( ) Left arm ( ) Both

My pain is worse when I:

Cough or Sneeze	( ) Yes	( ) No
Bend Forward	( ) Yes	( ) No
Lift	( ) Yes	( ) No
Push	( ) Yes	( ) No
Pull	( ) Yes	( ) No
Turn my Head	( ) Yes	( ) No

My pain wakes me during the night: ( ) Yes ( ) No

Weather changes affect my pain: ( ) Yes ( ) No

I have neck stiffness: ( ) Yes ( ) No

I have headaches: ( ) Yes ( ) No

If I do get headaches, they occur ( ) Sometimes ( ) All of the time

BACK PAIN:

Currently, I have pain in my:	( ) Low Back	( ) Mid Back	( ) Upper Back
My Pain Began:	( ) Gradually	( ) Suddenly	
I Have Pain:	( ) Sometimes	( ) All of the time	
My Pain goes into my	( ) Right Leg	( ) Left Leg	( ) Both
I have tingling/numbness in my:	( ) Right Leg	( ) Left Leg	( ) Both

My pain is worse when I:

Cough or sneeze	( ) Yes	( ) No
Sit	( ) Yes	( ) No
Bend	( ) Yes	( ) No
Walk	( ) Yes	( ) No
Lift	( ) Yes	( ) No
Push	( ) Yes	( ) No
Pull	( ) Yes	( ) No

My pain is worse with sexual activity:	( ) Yes	( ) No
My pain wakes me up at night:	( ) Yes	( ) No
Changes in weather affect my pain:	( ) Yes	( ) No

OTHER PAIN:

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition:

____

____

____

JOB DESCRIPTION

PLEASE CIRCLE THE ***NUMBER OF HOURS*** THAT YOU PERFORM THE FOLLOWING ACTIVITIES IN A TYPICAL WORK DAY:

SITTING:	1	2	3	4	5	6	7	8	HOURS / DAY
STANDING:	1	2	3	4	5	6	7	8	HOURS / DAY
WALKING:	1	2	3	4	5	6	7	8	HOURS / DAY

ON THE JOB, I NORMALLY PERFORM THE FOLLOWING ACTIVITIES:

	NOT AT ALL *0% OF WORK DAY*	**OCCASIONALLY** *1 – 33% OF WORK DAY*	**FREQUENTLY** *34 – 66 % OF WORK DAY*	**CONTINUOUSLY** *67 – 100% OF WORK DAY*
BEND / STOOP:	( )	( )	( )	( )
SQUAT:	( )	( )	( )	( )
CRAWL:	( )	( )	( )	( )
CLIMB:	( )	( )	( )	( )
REACH ABOVE SHOULDER LEVEL:	( )	( )	( )	( )
CROUCH:	( )	( )	( )	( )
KNEEL:	( )	( )	( )	( )
BALANCE:	( )	( )	( )	( )
PUSH/PULL:	( )	( )	( )	( )

ON THE JOB, I NORMALLY LIFT:

	NOT AT ALL *0% OF WORK DAY*	**OCCASIONALLY** *1 – 33% OF WORK DAY*	**FREQUENTLY** *34 – 66 % OF WORK DAY*	**CONTINUOUSLY** *67 – 100% OF WORK DAY*
UP TO 10 LBS:	( )	( )	( )	( )
11 TO 24 LBS:	( )	( )	( )	( )
25 TO 34 LBS:	( )	( )	( )	( )
35 TO 50 LBS:	( )	( )	( )	( )
51 TO 74 LBS:	( )	( )	( )	( )
75 TO 100 LBS:	( )	( )	( )	( )

DO YOU HAVE TO BEND WHILE DOING ANY LIFTING? ( ) YES ( ) NO

ARE YOUR FEET USED FOR REPETITIVE MOVEMENTS, SUCH AS OPERATING FOOT CONTROLS, ETC.? ( ) YES ( ) NO

DO YOU USE YOUR HANDS FOR REPETITIVE ACTIONS, SUCH AS:

	SIMPLE GRASPING	**FIRM GRASPING**	**FINE MANIPULATING**
RIGHT HAND:	( ) YES ( ) NO	( ) YES ( ) NO	( ) YES ( ) NO
LEFT HAND:	( ) YES ( ) NO	( ) YES ( ) NO	( ) YES ( ) NO

ARE YOU REQUIRED TO WORK ON UNPROTECTED HEIGHTS? ( ) YES ( ) NO
IF *YES*, DESCRIBE:____
____
____

ARE YOU REQUIRED TO BE AROUND MOVING MACHINERY? ( ) YES ( ) NO
IF *YES*, DESCRIBE:____
____
____

ARE YOU EXPOSED TO MARKED CHANGES IN TEMPERATURE AND HUMIDITY? ( ) YES ( ) NO
IF *YES*, DESCRIBE:____
____
____

ARE YOU REQUIRED TO DRIVE AN AUTOMOBILE OR OTHER EQUIPMENT? ( ) YES ( ) NO
IF *YES*, DESCRIBE:____
____

ARE YOU EXPOSED TO DUST, FUMES AND/OR GASES? ( ) YES ( ) NO
IF *YES*, DESCRIBE:____
____
____

HAVE YOU HAD ANY OTHER ACCIDENTS WHICH REQUIRED MEDICAL CARE? ( ) YES ( ) NO
IF *YES*, DESCRIBE:____
____
____

HAVE YOU HAD ANY SERIOUS ILLNESS THAT REQUIRED HOSPITALIZATION? ( ) YES ( ) NO
IF *YES*, DESCRIBE:____
____
____

HAVE YOU HAD ANY SURGERIES? ( ) YES ( ) NO
IF *YES*, PLEASE LIST TYPE OF SURGERY AND DATE:____
____
____

HAVE YOU HAD ANY NERVOUS OR MENTAL ILLNESS? ( ) YES ( ) NO

HAVE YOU HAD PSYCHIATRIC CARE? ( ) YES ( ) NO

HAVE YOU RECEIVED A MEDICAL DISCHARGE FROM THE ARMED FORCES? ( ) YES ( ) NO

HAVE YOU RETURNED TO WORK SINCE THE ACCIDENT? ( ) YES ( ) NO

IF YOU HAVE RETURNED TO WORK SINCE THE ACCIDENT, PLEASE FILL OUT THE INFORMATION BELOW:

DATE	*EMPLOYER*	*OCCUPATION*	*LIGHT DUTY/REG DUTY*	*FULL TIME/PART TIME*

AGREEMENT TO PAY MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE OR IF COMPENSATION CLAIM IS DENIED

WORKERS COMP. BOARD CASE # (*if known*): ____________________________ DATE OF INJURY: ________________

CARRIER CASE # (*if known*): ____

CLAIMANT / INJURED PARTY: ____ SOCIAL SECURITY #: ________________

CLAIMANT'S ADDRESS: ____
(*with apartment # if applicable*)

NATURE OF INJURY / ILLNESS: ____

EMPLOYER'S NAME: ____

EMPLOYER'S ADDRESS: ____

EMPLOYER'S INSURANCE COMPANY NAME: ____

EMPLOYER'S INSURANCE COMPANY ADDRESS: ____

IN THE EVENT I FAIL TO PROSECUTE THE CLAIM FOR WORKERS COMPENSATION FOR THIS ILLNESS OR CONDITION OR IT IS DETERMINED BY THE WORKERS COMPENSATION BOARD THAT THE ILLNESS OR CONDITION IS NOT A RESULT OF A COMPENSABLE WORKERS COMPENSATION CASE,

I, ____________________________________, HEREBY AGREE TO PAY NATURALLY CHIROPRACTIC, P.C. (*B.*
[Claimant / Injured Party]

***BURFORD, D.C. / L. MILANOVICH, D.C. / CHRISTIAN STACK, D.C.*) ANY AND ALL USUAL AND CUSTOMARY FEES FOR SERVICES RENDERED TO THE ABOVE NAMED CLAIMANT IN THE ABOVE IDENTIFIED CASE.**

*SIGNATURE*______________________________________ *DATE*_________________________

If signed by someone other than the claimant, then print below full name, address and relationship to the claimant.

*NAME & ADDRESS*____ *RELATIONSHIP* ____________________

Prescribed by Chairman
Workers Compensation Board - State of New York