# 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 #: _____

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## W O R K M E N ' S  C O M P E N S A T I O N
## * O U R  O F F I C E  P O L I C Y *

All on the job injuries should be reported to your employer before coming to this office so that coverage can be determined. Workmen's Compensation claims must be approved by the business office before services are rendered. Patients accepted on Workmen's Compensation will be allowed to continue treatment without personal payment. If the case is not paid by the insurance company, the patient is responsible for all debt he or she incurs. Patient must sign appropriate paperwork when cases are controverted.

Here is hoping that we have a long and fruitful relationship.

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Legal/Collection Fee: I agree to pay **ALL** reasonable fees of attorneys and/or collection agencies needed to affect collection of any delinquent charges outstanding on my account. I also agree that, if at anytime there is need for legal action to be brought against my employer and/or Workmen's Compensation insurance company, I will be responsible for instigating such action.

I have carefully read the above and fully understand the policies of this office. I have also been given a copy of this agreement.

Date _____ Signed _____
Patient's Signature

Witnesses to Patient's Signature _____

_____