Rafey Chiropractic and Health Center

Achieving Your Health Success.

WORKER'S COMPENSATION PATIENT HISTORY

1 Date of occupational injury: _______ / _______ / _______ Time of injury: __ : _____ a.m. / p.m.

Date the occupational injury was reported and documented by your employer: _______ / _______ / _______

2 Location of injury: on employee premises ___ working for employer not directly on employer premises
__ driving company vehicle ___ passenger in company vehicle

3 Type of work being done at the time of the work injury: ______________________________

4 Complete and accurate description of the work injury by the patient: ______________________________

5 Doctors additional comments regarding the specifics of the mechanism of injury: ______________________________

6 Nature of onset and initial description of all symptoms experienced by the injured worker: ______________________________

7 Work status immediatley post injury:
__ continued to work with no change in pain
__ continued to work with increasing pain
__ continued to work initially and stopped working due to increased pain
__ stopped working immediately due to pain

8 Work status next day following injury
__ returned to work full duty with pain and pain increased with work
__ returned to work full duty with pain and pain was not increased with work
__ returned back to work on light duty and pain increased with work
__ returned back to work on light duty and pain not increased with work
__ unable to return to work due to pain: date last worked: ______________

9 Since the work injury, what activities especially at work, increase your symptoms ______________________________

10 Type of treatment received by injured worker for this new occupational injury

__ none to date
__ Urgent care center - exam, medication (yes / no), and released
__ Urgent care center - exam, x-ray, medication (yes / no), and released
__ Employer recommended facility (________________________) exam, meds, and released
__ Employer recommended facility (________________________) exam, x-rays, meds and released
__ Emergency Room (Hospital ________________________) exam, meds, and released
__ Emergency Room (Hospital ________________________) exam, x-rays, meds, and released
__ Family physician: name and date: ________________________
__ Medical specialist (ortho, neuro, physical medicine, physical therapy, etc.): ____________

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__ Independent medical exams: who & dates: ________________________

11 If this is an established work injury, list all previous treatment that you have had associated with this injury

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12 Immediately following the injury, I was treated by:

__ none to date
__ Urgent care center - exam, medication (yes / no), and released
__ Urgent care center - exam, x-ray, medication (yes / no), and released
__ Employer recommended facility (________________________) exam, meds, and released
__ Employer recommended facility (________________________) exam, x-rays, meds, and released
__ Emergency Room (Hospital ________________________) exam, meds, and released
__ Emergency Room (Hospital ________________________) exam, x-rays, meds, and released
__ Family physician: name and date ________________________
__ Medical specialist (ortho, neuro, physical medicine, physical therapy, etc.): ____________

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13 After my initial treatment to current, I have seen the following (who and when):

__ No other physician or specialist seen
__ Chiropractor:
__ Physical therapy:
__ Orthopedic surgeon
__ Neurologist / neurosurgeon
__ PM&R / occupational medicine:
__ Diagnostic imaging (MRI, CT, myelogram):
__ Diagnostic testing (NCV / EMG, etc.):
__ Independent medical exams:

Please Read: In order for the treating doctor to have an accurate history of my occupational injury as well as all treatment that I have received, by signing below, I authorize Rafey Chiropractic and Health Center to obtain my medical records pertaining to this occupational injury that occurred on ____________

Patient Name ________________________ Date: ______ / ______ / ______

Claim #: ________________________

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Doctor's Signature Date

(Doctor's signature indicates review of above questions with the patient)