EMPLOYMENT ACCIDENT HISTORY

Simply Aligned Chiropractic
3445 Orchard Park Road, Orchard Park, NY 14127
Practice of Dr. Scott Przybyla

Has injury been reported? ☐Yes ☐No Has care been authorized? ☐Yes ☐No

Employer's insurance: _____ Policy #: _____ Group #: _____

Claim #: _____ Employer's Name: _____

Currently an employee? ☐Yes ☐No Phone: _____

Employer Address/City/State: _____

Is there an Attorney involved? ☐Yes ☐No Firm: _____

Name: _____ Phone: _____

Address/City/ State: _____

Date and time of accident/injury: _____

Address/location where you were injured:

_____

In your own words, please describe the accident:

_____

_____

Did you lose consciousness during the accident? ☐Yes ☐No If yes, for how long? _____

Have you gone to a hospital or seen any other doctor? ☐Yes ☐No

When did you go? ☐Same day ☐Next day ☐2+ days

Describe any treatment you received? _____

Are you currently receiving any type of care? ☐Yes ☐No If yes, please describe:

_____

Have you been able to work since this injury? ☐Yes ☐No

Are your work activities restricted because of this injury? ☐Yes ☐No

Is there any activity or duty you are unable or find difficult to perform, please describe:

_____

Are you wearing any type of brace or support? ☐Yes ☐No

Describe your routine job duties:

_____

How often does your job require you do the following? Please circle:

Grasping:	25%	50%	75%	90-100% of the time.
Twisting/bending:	25%	50%	75%	90-100% of the time.
Squatting/kneeling:	25%	50%	75%	90-100% of the time.
Walking:	25%	50%	75%	90-100% of the time.
Climbing:	25%	50%	75%	90-100% of the time.
Push/pull:	25%	50%	75%	90-100% of the time.
Reach overhead:	25%	50%	75%	90-100% of the time.

Indicate the symptoms that are the result of this accident:

☐Dizziness	☐Blurred Vision	☐Neck pain	☐Numb feet/toes	☐Arm pain
☐Insomnia	☐Tension	☐Chest pain	☐Shortness of breath	☐Shoulder pain
☐Jaw issues	☐Back stiffness	☐Leg pain	☐Numb fingers/hands	☐Stiff neck
☐Nausea	☐Buzzing in ears	☐Ears ringing	☐Memory loss	☐Headaches
☐Irritability	☐Back pain	☐Lower back pain	☐Stomach upset	☐Fatigue

Have you ever been injured at work prior to this accident/injury? ☐Yes ☐No

If yes, please explain:

_____

Were you determined to have any permanent impairment/disability? ☐Yes ☐No

To the best of your knowledge, has this accident occurred in your workplace before? ☐Yes ☐No

Did you have any physical complaints BEFORE the accident? ☐Yes ☐No

Is your condition getting worse? ☐Yes ☐No

I understand the above information and guarantee the forms completed today were completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____