MOVEMENT CLINIC

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Workers' Compensation History

Was your accident directly related to your work? Yes ☐ No ☐

Briefly describe the events that occurred just before and during your accident:

_____

_____

_____

_____

Did you report your accident to your employer? Yes ☐ No ☐

Did your accident render you unconscious? Yes ☐ No ☐

If yes, for how long? _____

Please describe how you felt immediately after the accident:

_____

_____

_____

Describe any treatment you received:

_____

_____

_____

Were x-rays taken? Yes ☐ No ☐

Was medication prescribed? Yes ☐ No ☐

If yes, what types? _____

Are your work activities restricted as a result of this injury? Yes ☐ No ☐

Indicate the symptoms that are a result of this accident:

☐ Dizziness	☐ Headache	☐ Ears Ringing or Buzzing
☐ Difficulty Sleeping	☐ Fatigue	☐ Neck Pain
☐ Arm or Shoulder Pain	☐ Chest Pains	☐ Stomach Upset or Nausea
☐ Upper or Middle Back Pain	☐ Back Stiffness	☐ Stiff Neck
☐ Memory Loss	☐ Blurred Vision	☐ Jaw Problems
☐ Irritability	☐Tension	☐ Leg Pain
☐ Numb Hands or Fingers	☐ Shortness of Breath	☐ Other: _____
☐ Lower Back Pain	☐ Numb Feet or Toes	

Please indicate level of discomfort due to injury for each of the following activities.

	Comfortable	Uncomfortable	Painful
Lying on Back	☐	☐	☐
Lying on Side	☐	☐	☐
Lying on Stomach	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Sexual Activity	☐	☐	☐
Walking Short Distance	☐	☐	☐
Running	☐	☐	☐
Sports	☐	☐	☐
Bending Forward	☐	☐	☐
Operating Equipment	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐
Lifting	☐	☐	☐
Driving	☐	☐	☐
Twisting	☐	☐	☐
Crawling	☐	☐	☐
Working	☐	☐	☐
Lifting	☐	☐	☐
Typing	☐	☐	☐
Stooping	☐	☐	☐

Employer Information

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of employer/supervisor ***who authorized treatment at this office***: _____

My employer and I have filed a Workers' Compensation claim: Yes ☐ No ☐

Claim Number: _____

Name of contact person for my workers' compensation claim: _____ Phone: _____

Attorney Information

I have retained an attorney: Yes ☐ No ☐

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Signature: _____ **Date:** _____

Please note this form is to be used in conjunction with any forms required by your state's workers' compensation board. This form is not intended to be a substitute for any state or other authority's forms.