Work Comp History

Patient Name _____
Name of Compensation Carrier _____
Address of Carrier _____ City _____ State ____ Zip _____
Employer's Name _____ Address _____
Type of Business _____ Your Occupation _____
Date Injured _____ Hour _____ AM/PM Last Date Worked _____
Previous Workers' Compensation Injury? ( ) Yes ( ) No
Accident reported to Employer? Yes / No Name of person reported accident to _____
Injured at _____ City _____ State _____ Zip _____
Length of time worked there prior to accident _____
Type of work being done at time of injury _____
In your own words, please describe the accident (time, date, place) _____
_____
_____
Have you been treated by another doctor for this accident? ( ) Yes ( ) No
If yes, please provide Doctor's name and address _____
What type of treatment did you receive? _____
How long were you treated by this doctor? _____
Have you had any tests related to this injury ( ) Yes ( ) No If Yes, list: _____
Are you: ( ) Improved ( ) Unchanged ( ) Getting worse
What type of medicines are you taking? _____
Do these medicines help? ( ) Yes ( ) No ( ) Don't know
Have you had physical therapy? ( ) Yes ( ) No If Yes, please provide Physical Therapist's name and address
_____
If yes, how often? ( ) Daily ( ) Every other day ( ) Several times a week ( ) Weekly ( ) Every other week
How long _____ Type _____
Does the physical therapy help? ( ) Yes ( ) No ( ) Don't know

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 similar complaints the results of a previous accident(s)? ( ) Yes ( ) No
If yes, please provide details of accident(s) _____
_____
Have you had any nervous or mental illnesses? ( ) 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 this accident? ( ) Yes ( ) No
If you have returned to work since your accident, please fill out the information below:

Date	Employer	Occupation	Light Duty Reg Duty	Full Time Part Time

Are you required to work on unprotected heights? ( ) Yes ( ) No
Are you required to be around moving machinery? ( ) Yes ( ) No
Are you exposed to marked changes in temperature and humidity? ( ) Yes ( ) No
Are you required to drive automotive equipment? ( ) Yes ( ) No
Are you exposed to dust, fumes and/or gases? ( ) Yes ( ) No

Please list any additional comments: _____
_____

CURRENT MEDICAL COMPLAINTS

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 and/or 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 back is worse with sexual activity	( ) Yes ( ) No
My pain wakes me up during the night	( ) Yes ( ) No
Changes in the weather affect my pain	( ) Yes ( ) No

NECK PAIN

My neck 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 or numbness in my:	( ) Right Leg ( ) Left Leg ( ) 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 up during the night	( ) Yes ( ) No
Changes in the weather 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

OTHER PAIN

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

_____

_____ _____

Patient Signature Date

Strelcheck Chiropractic and Massage Clinic
10 N. Virginia Street · Crystal Lake · Illinois · 60014
815-459-3860