

COLLINS CHIROPRACTIC, PA 14033 Commerce Ave. N.E. Prior Lake, MN. 55372

PATIENT WORKER'S COMPENSATION CONFIDENTIAL

Patient Name _____ Date _____

Street
Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Date of Birth _____ Female _____ Male _____ SSN# _____

Employer Name _____

Employer Address _____

City _____ State _____ Zip _____

Employer Phone _____ Occupation _____

Worker's Compensation Company Name _____

Address _____

Worker's Compensation Claim Number _____

Date of Injury _____ Time of Injury _____

Primary Insurance Company _____ ID# _____

Attorney _____

Address _____ City _____ State _____ Zip _____

Phone Number _____ Contact Person _____

1. What were you doing at the time you were injured? How did the accident/injury happen (lifting, bending, walking, carrying, standing, etc.)?

2. When did pain begin? Where did you first feel it? Was pain intense at first, or did you feel pain that gradually worsened? Please be specific.

3. Describe the physical conditions which may have contributed to your present injury: Darkness, faulty equipment, slippery floor, limited space. (Distinguish natural hazards from hazards created by other employees, such as housekeepers).

4. Date Reported _____ Supervisor Name _____
Witness to Accident _____

5. Were you hospitalized as a result of this accident? Yes _____ No _____
If yes, where? _____
Attending Physician _____
X-rays taken? Yes _____ No _____ Treatment plan _____

6. Have you ever had any prior injuries, accidents, diseases, or treatment to the area of your body now affected? Yes _____ No _____ If yes, answer specific dates and treatment plans _____

7. When was the last time you felt pain or problems from that injury? _____

8. Have you lost any time from work as a result of this injury? Yes _____ No _____
If yes, please give dates _____

9. Please list what restrictions you have been place on _____

10. If you have gone back to work, please list the activities that are:
 Painful _____ Difficult _____
11. Are there any other reasons/issues that need to be discussed with your doctor?

12. On a scale of 1-10, with 1 being: "I'm pain free and can function quite well." &
 10 being: "I'm in pain all the time and cannot function at all."
 Where would you rate yourself? 1 2 3 4 5 6 7 8 9 10. Please explain why.

13. Do you find any activities that you perform at home painful or difficult? _____
 If yes, please explain _____

List surgical operations and years _____

List all medications you are now taking _____

Have you ever suffered from: Dizziness _____ Backaches _____ Heart Trouble _____
 Diabetes _____ Arthritis _____ Headaches _____ Asthma _____ Neuritis _____
 Digestive Disorders _____ Nervousness _____ Sinus Trouble _____ Neck Pain _____

PLEASE INFORM THE DOCTOR OF ANY FAMILY HEALTH INFORMATION THAT
 WOULD BE IMPORTANT TO YOUR TOTAL HEALTH PICTURE.

 PATIENT/GUARDIAN SIGNATURE DATE