PATHWAYS
CHIROPRACTIC HEALTH CENTER

WORKER'S COMPENSATION HISTORY INFORMATION

(Please fill out all information completely, indicate N/A if not applicable)

16154 Main Ave SE, Prior Lake, MN 55372 Phone
(952)447-3000 Fax (952)447-3561

Patient's Name _____ **Date of injury** _____ **Time** _____ AM/PM

Name of Employer _____ **Telephone Number** _____

Address of Employer/where injury occurred _____

Was injury reported to management? ☐ **YES** ☐ **NO** **If Yes, Whom/ Date** _____

Have you lost time from work? ☐ **YES** ☐ **NO** **If Yes, What is the last day worked?** _____

Have you been treated by another doctor for this accident? ☐ **YES** ☐ **NO**

If YES, Name of Doctor(s) _____

Length of time worked there prior to accident: _____

Did anyone witness the accident? ☐ **YES** ☐ **NO** **If YES, who?** _____

In your own words, please describe how the accident happened:

_____

_ _____

_____

Since the injury, are you: **Improved** **Unchanged** **Getting Worse**

Have you had Physical Therapy? ☐ **Yes** ☐ **No**

Does Physical Therapy help? ☐ **Yes** ☐ **No** **If yes, how often?** _____

Prior to this injury, have you ever had any of the physical complaints similar to what you have now? ☐ **YES** ☐ **NO**

If YES, please describe _____

Were these similar complaints the result of a previous injury? ☐ **YES** ☐ **NO** **If YES, please describe:** _____

_____

Have you had any other serious injuries which required medical care? ☐ **YES** ☐ **NO** **If YES, please describe:** _____

_____

Have you had a previous Worker's Compensation injury? ☐ **YES** ☐ **NO**

If YES, Date(s) of previous injury _____

CURRENT PHYSICAL COMPLAINTS

BACK PAIN: (Mark this area *only* if pertains to injury)

1. Currently, I have pain in my ☐Low Back ☐Mid Back ☐Upper Back
2. My pain began: ☐Gradually ☐Suddenly
3. I have pain: ☐Sometime ☐All of the time

BACK PAIN CONTINUED:

4. My pain goes into my: ☐Right Leg ☐Left Leg ☐Both Legs
5. I have tingling/numbness in: ☐Right Leg ☐Left Leg ☐Both Legs
6. 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

7. My back is worse with sexual activity ☐Yes ☐No
8. My pain wakes me up during the night ☐Yes ☐No
9. Changes in the weather affect my pain ☐Yes ☐No

NECK PAIN: (Mark this area *only* if pertains to injury)

10. My neck pain began ☐Gradually ☐Suddenly
11. I have pain: ☐Sometimes ☐All of the time
12. My pain goes into my: ☐Right Arm ☐Left Arm ☐Both Arms
13. I have tingling/numbness in: ☐Right Arm ☐Left Arm ☐Both Arms

14. 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
15. My pain wakes me up during the night ☐Yes ☐No
16. Changes in the weather affect my pain ☐Yes ☐No
17. I have neck stiffness ☐Yes ☐No
18. I have headaches ☐Yes ☐No
19. If I do get headaches, they occur ☐Sometimes ☐All of the time

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

_____

_____

Patient's Signature: _____ Date: _____

Information Taken By: _____ Date: _____