NORTH SUBURBAN FAMILY CHIROPRACTIC

Work-Related Accident Questionnaire

EMPLOYER INFORMATION

NAME OF EMPLOYER AT TIME OF ACCIDENT?

LENGTH OF TIME WORKED THERE PRIOR TO ACCIDENT?

TYPE OF WORK BEING DONE AT TIME OF INJURY?

IN A TYPICAL 8-HOUR WORKDAY, I (CIRCLE # OF HOURS/ACTIVITY)

SIT	1	2	3	4	5	6	7	8	HOURS
STAND	1	2	3	4	5	6	7	8	HOURS
WALK	1	2	3	4	5	6	7	8	HOURS

ON THE JOB, I PERFORM THE FOLLOWING ACTIVITIES:

	NOT AT ALL	*OCCASIONALLY*	*FREQUENTLY*	*CONTINUOUSLY*
SQUAT	☐	☐	☐	☐
CRAWL	☐	☐	☐	☐
CLIMB	☐	☐	☐	☐
REACH UP	☐	☐	☐	☐
CROUCH	☐	☐	☐	☐
KNEEL	☐	☐	☐	☐
BALANCING	☐	☐	☐	☐
BENDING	☐	☐	☐	☐
PUSH/PULL	☐	☐	☐	☐

ON THE JOB, I LIFT:

	NOT AT ALL	*OCCASIONALLY*	*FREQUENTLY*
UP TO 10 LBS.	☐	☐	☐
11 TO 24 LBS.	☐	☐	☐
25 TO 34 LBS.	☐	☐	☐
35 TO 50 LBS.	☐	☐	☐
51 TO 74 LBS.	☐	☐	☐
75 TO 100 LBS.	☐	☐	☐

DO YOU HAVE TO BEND OVER WHILE DOING ANY LIFTING:
☐YES ☐NO

ARE YOUR FEET USED FOR REPETITIVE MOVEMENTS, SUCH AS IN OPERATING FOOT CONTROLS? ☐YES ☐NO

DO YOU USE YOUR HANDS FOR REPETITIVE ACTIONS SUCH AS *SIMPLE GRASPING*, *FIRM GRASPING* OR *FINE MANIPULATING?* (PLEASE CIRCLE ONE).

ARE YOU EXPOSED TO MARKED CHANGES IN TEMPERATURE AND HUMIDITY? ☐YES ☐NO
DESCRIBE: _____

ACCIDENT / INJURY INFORMATION

IN YOUR OWN WORDS, PLEASE DESCRIBE THE ACCIDENT:

DID YOU REPORT THE ACCIDENT TO YOUR SUPERVISOR(S) AND FILE APPROPRIATE CLAIM FORMS? ☐YES ☐NO

HAVE YOU BEEN TREATED BY ANOTHER DOCTOR FOR THIS ACCIDENT? ☐YES ☐NO

IF YES, PLEASE LIST DOCTOR'S NAME, ADDRESS AND PHONE NUMBER:

WHAT TYPE(S) OF TREATMENT DID YOU RECEIVE?

HOW LONG WERE YOU TREATED BY THIS DOCTOR?

ARE YOU: ☐IMPROVED ☐SAME ☐GETTING WORSE
NOTES:

WHAT TYPE(S) OF MEDICINE ARE YOU TAKING?
☐ANTI-INFLAMMATORY (ASPIRIN, MOTRIN, ETC.)
☐MUSCLE RELAXERS ☐PAIN RELIEVERS
☐TRANQUILIZERS ☐ANTI-DEPRESSANTS
☐OTHER

DO THESE MEDICINES HELP? ☐YES ☐NO
NOTES:

HAVE YOU HAD PHYSICAL THERAPY? ☐YES ☐NO
IF YES, HOW OFTEN:
☐ Daily ☐ Every other day ☐ Several times weekly
☐ Every two weeks ☐ Monthly ☐ Other

PRIOR TO THIS ACCIDENT, HAVE YOU EVER HAD ANY 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
PLEASE PROVIDE DETAILS OF ACCIDENT(S): _____

CONTINUED ON OPPOSITE SIDE

Accident / Injury Questionnaire

IMMEDIATELY AFTER ACCIDENT / INJURY

DID YOU LOSE CONSCIOUSNESS?
❑ Yes ❑ No ❑ Don't know

HOW DID YOU FEEL?
❑ Confused ❑ Dazed ❑ Dizzy ❑ Nervous
❑ Weak ❑ Other

WHERE DID YOU IMMEDIATELY DEVELOP PAIN?

❑ Head	❑ Shoulders	❑ Buttocks
❑ Neck	❑ Arms	❑ Hips
❑ Upper/Mid Back	❑ Elbows	❑ Thighs
❑ Lower Back	❑ Forearms	❑ Knees
❑ Pelvis	❑ Wrists	❑ Legs
❑ Chest/Rib cage	❑ Hands	❑ Ankles
❑ Abdomen	❑ Feet	
❑ Other		

IF THERE WERE CUTS, WHERE WERE THEY?

DESCRIBE ANY OTHER SIGNIFICANT INJURY:

EMERGENCY CARE AT ACCIDENT / INJURY SITE
DID YOU RECEIVE EMERGENCY CARE? ❑YES ❑NO

WHAT TYPE OF EMERGENCY CARE DID YOU RECEIVE?
❑ Bandages ❑ Splints ❑ Brace ❑ Neck Collar
❑ Other

DESTINATION AFTER ACCIDENT / INJURY

Where did you go?		By whom were you driven?	
❑ Hospital	❑ Home	❑ Myself	❑ Ambulance
❑ School	❑ Work	❑ Friend	❑ Family
❑ Other		❑ Other	

HOSPITAL VISIT AFTER ACCIDENT / INJURY

WHEN DID YOU GO TO THE HOSPITAL?
❑Immediately ❑Later that day ❑Next day ❑Days later
❑ Date ___/___/___ ❑ Other

HOSPITAL NAME:	EXAMINED BY DOCTOR:
Admitted: ❑Yes ❑No	Date released ___/___/___

IF X-RAYS WERE TAKEN, OF WHAT BODY PART(S)?

IF A CAT SCAN WAS PERFORMED, OF WHAT BODY PART(S)?

IF AN MRI WAS PERFORMED, OF WHAT BODY PART(S)?

WHAT TREATMENT WAS ADMINISTERED AT THE HOSPITAL?

❑Medication	❑Sutures	❑Splint	❑Collar
❑Injection	❑Ice packs	❑Cast	❑Support
❑Antiseptics	❑Hot Packs	❑Brace	❑Surgery
❑Bandages	❑Other		

INSTRUCTIONS GIVEN WHEN DISCHARGED FROM HOSPITAL
WERE YOU TOLD TO SEE

❑General practitioner	❑Chiropractor	❑Neurologist
❑Physical Therapist	❑Orthopedist	❑Internist
❑General Surgeon	❑Plastic Surgeon	
❑Other		

WHAT RECOMMENDATIONS WERE MADE?

❑ No further care	❑ No follow-up care	❑ Observation
❑ Rest	❑ Heat	❑ Ice
❑ Support	❑ Time off work	❑ Collar

WERE MEDICATION PRESCRIBED?
❑ Pain ❑ Anti-inflammatory ❑ Antibiotic ❑ Nervousness
❑ Other

FOLLOWING THE ACCIDENT / INJURY

HOW MUCH LATER DID ADDITIONAL SYMPTOMS DEVELOP?
❑ Immediately ❑ Hours ❑ That evening ❑ Next morning
❑ Days ❑ Week ❑ Month ❑

WHAT ADDITIONAL SYMPTOMS DEVELOPED?

SINCE YOUR ACCIDENT/INJURY HAVE YOU SUFFERED FROM?

❑ Blurred vision	❑ Chest pain	❑ Nausea
❑ Double vision	❑ Labored breathing	❑ Vomiting
❑ Reduced vision	❑ Palpitations	❑ Frequent urination
❑ Impaired hearing	❑ Constipation	❑ Painful urination
❑ Ringing in ears	❑ Diarrhea	❑ Restlessness
❑ Anxiety	❑ Convulsions	❑ Insomnia
❑ Depression	❑ Dizziness	❑ Light sensitivity
❑ Mood swings	❑ Headaches	❑ Reduced appetite
❑ Nervousness	❑ Fainting	❑ Weakness
❑ Poor memory	❑ Loss of balance	❑ Weight gain
❑ Tension	❑ Fatigue	❑ Weight loss

ARE YOU RESTRICTED IN ANY OF THE FOLLOWING AREAS AS A RESULT OF THIS ACCIDENT?
❑ Daily living ❑ Occupational ❑ Recreational
❑ Other

HAVE YOU MISSED WORK DUE TO THIS ACCIDENT/INJURY?
❑ Missed no work ❑Limited work activity
❑ Missed from: ___/___/___ to ___/___/___
❑ Other

DID YOU SELF TREAT YOUR SYMPTOMS?
❑ Ice ❑ Heat ❑ Bed rest ❑ Medic
❑ Other

DID YOU SEEK MEDICAL CARE ELSEWHERE?

General Practitioner	Name:
Diagnosis and treatment:	
Chiropractor	Name:
Diagnosis and treatment:	
Neurologist	Name:
Diagnosis and treatment:	
Orthopedist	Name:
Diagnosis and treatment:	