

Which areas of your body were X-Rayed? ()NECK ()MID BACK ()LOW BACK ()OTHER _____
 Was any treatment administered at the hospital? ()ICE ()HEAT ()CERVICAL COLLAR ()MEDICATION
 FOLLOW UP INSTRUCTIONS: _____

OTHER HEALTH CARE PROVIDERS SEEN AFTER THE ACCIDENT:

1) Dr. _____ Specialty: _____ Referred By: _____

Date first seen: (__ / __ / ____) Treatment type: _____
 Treatment frequency/duration _____ Currently treating? ()YES ()NO
 Any disability? () YES () NO If YES, please describe _____
 Special tests (X-Rays, MRI, CT): _____ Did treatments help? ()YES ()NO

2) Dr. _____ Specialty: _____ Referred By: _____

Date first seen: (__ / __ / ____) Treatment type: _____
 Treatment frequency/duration _____ Currently treating? ()YES ()NO
 Any disability? () YES () NO If YES, please describe _____
 Special tests (X-Rays, MRI, CT): _____ Did treatments help? ()YES ()NO

QUESTIONS ABOUT YOUR WORK AND SOCIAL HISTORY:

What is your occupation? _____
 Employer at time of injury? _____ Employers Phone #? _____
 Employers Address: _____
 Is this accident an *on the job injury*? ()YES ()NO If YES, have you reported it to your employer? ()YES ()NO
 Has an *on the job injury claim* been filed? ()YES ()NO If YES, what is the claim number? _____
 Have you lost time from work as a result of this injury? ()YES ()NO If YES, please list dates _____
 Date you returned to work or expect to return to work _____
 I am currently working: () FULL-TIME () PART-TIME _____ (HRS/WEEK) () REGULAR DUTY () LIGHT-DUTY

PLEASE CHECK THOSE ACTIVITIES THAT ARE REQUIRED OF YOU AT WORK:

LIFTING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	Up to ___ lbs
CARRYING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	Up to ___ lbs
PUSHING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	Up to ___ lbs
PULLING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	Up to ___ lbs
SITTING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	
STANDING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	
WALKING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	
BENDING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	

REACHING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	
TWISTING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	
COMPUTER WORK		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	

PLEASE CHECK THOSE ACTIVITIES THAT CAUSE WORSENING OF YOUR ACCIDENT RELATED INJURY:

LIFTING		SITTING		TWISTING		HOUSE WORK		
CARRYING		STANDING		REACHING		YARD WORK		
PUSHING		WALKING		EXERCISING		DRIVING		
PULLING		BENDING		COMPUTER WORK		OTHER _____		

SIGNATURE: _____

DATE: _____