

Okanagan Chiropractic ~ Work Injury Form

General Information: Today's Date: _____

Patient Name: _____

Date of Injury: _____ Time: _____

S.I.N.: _____ WCB#: _____

Employment Details:

Employers' Name _____

Occupation: _____

Work Ph#: _____ Mailing Address: _____

Location where injury occurred _____

If unemployed, is it due to the accident? Yes No

Type of work: Office/Clerical

Light labour Mod. labour Heavy labour

Habits:

Smoke: None _____ Pk/day _____ Years

Alcohol: Never Social Light Mod Heavy

Past Medical History:

Surgery/Fractures (include dates): _____

WCB/ICBC/Personal injuries (dates, treatments, settlements): _____

Serious illnesses, Sports or other injuries to head, neck or back: _____

Any prior history of current complaints:

1. _____

2. _____

3. _____

Prior treatment by Chiropractor for these:

1. _____

2. _____

3. _____

Current Medical History:

Accident description: _____

Do you feel you have any physical limitations that prevent you from working in the same capacity as you were prior to the injury? _____

After the Injury:

Symptoms: head aches dizziness nausea

confusion neck/back pain tingling

If yes, where? _____

Where did you go after the accident? hospital

home work other _____

Mode of transportation: _____

Emergency Department:

X-Rays Taken: Yes No

Body parts x-rayed: _____

Cervical collar Ice Other: _____

Treatment: _____

Medications: _____

Follow up instructions: None Other _____

Treatment History:

1. Dr. _____
Type: _____
Date 1st seen: _____
Treatment type: _____
Treatment frequency: _____
Currently treating? Yes No
Any disability? Yes No
Did treatment help? Yes No
If yes, describe: _____
Special tests: _____

2. Dr. _____
Type: _____
Date 1st seen: _____
Treatment type: _____
Treatment frequency: _____
Currently treating? Yes No
Any disability? Yes No
Did treatment help? Yes No
If yes, describe: _____
Special tests: _____

Main Complaints:

Severity:

- ⇒1 = Minimal (a nuisance only)
- ⇒2 = Slight (causes slight handicap)
- ⇒3 = Moderate (causes significant handicap)
- ⇒4 = Severe (intolerable)

Amount of time:

- ⇒10% = rare
- ⇒25% = occasional
- ⇒50% = sporadic
- ⇒75% = frequent
- ⇒100% = constant

1. Body part: _____
Worsens when: _____
Relieved when: _____
Describe Pain: _____
Radiates (travels to): _____
Severity (1-4): _____
Amount of time in average day (as %): _____

2. Body part: _____
Worsens when: _____
Relieved when: _____
Describe pain: _____
Radiates (travels to): _____
Severity (1-4): _____
Amount of time in average day (as %): _____

3. Body part: _____
Worsens when: _____
Relieved when: _____
Describe pain: _____
Radiates (travels to): _____
Severity (1-4): _____
Amount of time in average day (as %): _____

4. Body part: _____
Pain began: _____
Worsens when: _____
Relieved when: _____
Describe pain: _____
Radiates (travels to): _____
Severity (1-4): _____
Amount of time in average day (as %): _____

5. Body part: _____
Pain began: _____
Worsens when: _____
Relieved when: _____
Describe pain: _____
Radiates (travels to): _____
Severity (1-4): _____
Amount of time in average day (as %): _____

Self Assessment as of Today:

% change positive or negative (list for separate areas)

1. _____
2. _____
3. _____
4. _____
5. _____