BALANCE POINT CHIROPRACTIC

WORK RELATED ACCIDENT FORM

ABOUT YOU

ABOUT YOU / EMPLOYER

NAME			TODAY'S DATE
EMPLOYER'S NAME			
EMPLOYER'S ADDRESS	CITY	STATE	ZIP
ATTORNEY'S NAME			
ATTORNEY'S ADDRESS	CITY	STATE	ZIP

ACCIDENT INFORMATION

ACCIDENT INFORMATION

DATE OF ACCIDENT	TIME OF ACCIDENT
PLEASE DESCRIBE THE INCIDENT IN A FEW SENTANCES:	
WAS THE ACCIDENT DIRECTLY RELATED TO WORK? ☐NO ☐YES	WAS ANYONE ELSE PRESENT DURING THE ACCIDENT? ☐NO ☐YES
DID YOU REPORT THE ACCIDENT TO YOUR SUPERVISOR? ☐NO ☐YES	WHAT IS YOUR SUPERVISOR'S NAME?
ADDRESS WHERE THE ACCIDENT OCCURRED (If different than employer's address)	
HAS THIS TYPE OF ACCIDENT HAPPENED TO YOU BEFORE? ☐NO ☐YES, Where_____ When_____	
TO THE BEST OF YOUR KNOWLEDGE, HAS THIS ACCIDENT OCCURRED IN YOUR WORKPLACE BEFORE? ☐NO ☐YES	
IS YOUR JOB PHYSICALLY STRESSFUL? ☐NO ☐YES	IS YOUR JOB MENTALLY STRESSFUL? ☐NO ☐YES
IS YOUR WORKPLACE NOISY? ☐NO ☐YES	HAVE YOU CHANGED JOBS IN THE LAST YEAR? ☐NO ☐YES

AFTER THE ACCIDENT

WHAT RECOMMENDATIONS DID YOUR EMPLOYER MAKE AFTER THE ACCIDENT?	
WERE YOU SENT TO ANOTHER DOCTOR AFTER THE ACCIDENT? ☐NO ☐YES, Name of Doctor: If yes, what did the other doctor say is wrong?	DID YOU GO TO A DOCTOR ON YOUR OWN? ☐NO ☐YES, Name of Doctor: If yes, what did the other doctor say is wrong?
PLEASE LIST TREATMENTS AND PRESCRIPTIONS YOU HAVE RECEIVED:	
ADVANCED IMAGING (please select all that apply): ☐None ☐X-ray ☐MRI AREA: ☐Skull ☐Neck ☐Mid-Back ☐Lower Back ☐Foot ☐Arm ☐Pelvis ☐Hips ☐Leg ☐Knee ☐Shoulder	
HAVE YOU BEEN ABLE TO WORK SINCE THIS INJURY? ☐NO ☐YES	HAVE WORK ACTIVITIES BEEN RESTRICTED? ☐NO ☐YES

Location of Problem(s) – PLEASE SELECT ALL THE APPLY

☐ Headaches	☐ Shoulder	☐ Hand	☐ Legs
☐ Jaw	☐ Arm	☐ Mid back	☐ Knee
☐ Neck	☐ Elbow	☐ Low back	☐ Ankle
☐ Upper back	☐ Wrist	☐ Hip	☐ Foot
☐ Other:			

IS THE CONDITION GETTING WORSE? ☐NO ☐YES ☐Constant ☐Comes & goes
WHAT MAKES THE PAIN BETTER?
WHAT MAKES THE PAIN WORSE?

ACTIVITIES & RECOVERY

Pain during activities

Activity	Comfortable	Uncomfortable	Painful
Lying on back	☐	☐	☐
Lying on side	☐	☐	☐
Lying on stomach	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Walking	☐	☐	☐
Running	☐	☐	☐
Sports	☐	☐	☐
Working	☐	☐	☐
Lifting	☐	☐	☐
Bending	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐

Work Recovery

HOW MANY HOURS DO YOU NORMALLY WORK PER DAY?

PLEASE INDICATE YOUR DAILY WORK DUTIES (Select all that apply)

☐ Standing ☐ Sitting ☐ Walking ☐ Lifting ☐ Driving

☐ Crawling ☐ Bending ☐ Typing ☐ Stooping ☐ Twisting

☐ Operating Equipment ☐ Working with arms above head

☐ Other:_____

Prior to this injury, were you able to work on an equal basis with others your age?

☐ NO ☐ YES ☐ Not Applicable

Do you work with others that can help you with heavy lifting?

☐ NO ☐ YES ☐ Not Applicable

Do you feel you are able to perform your normal work duties at this time?

☐ NO ☐ YES ☐ Not Applicable

Is there "Light Duty" work that you can request?

☐ NO ☐ YES ☐ Not Applicable

INSURANCE

Additional Insurance

TYPE OF INSURANCE	COMPANY NAME:
INSURED'S NAME:	PHONE#
ADDRESS:	
POLICY#:	CLAIM#
INSURED'S EMPLOYER	AGENT'S NAME

Signature

- If any of your medical or account information has changed, please inform our front desk personnel.
- Please remember, you are ultimately responsible for your account.

SIGNATURE:	DATE: