CARDINAL CHIROPRACTIC CENTERS®

Dr. Michael W. Baker

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WORK/ COMP. QUESTIONNAIRE

PATIENT INFORMATION												
Patient's last name:		First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)						
						Single / Mar / Div / Sep / Wid						
Is this your legal name?		Other legal or former name:		Social Security no.:		Birth date:		Age:	Sex:			
❑ Yes	❑ No					/ /			❑ M	❑ F		
Street address:			Apt. #:	E-mail address:		Home phone no.:						
						( )						
City:		State:		Zip Code:		Cell phone no.:						
						( )						
Occupation:			Employer:			Employer phone no.:						
						( )						
Name of Compensation Carrier:			Address of Carrier:			City:						
State:			Zip Code:			Carrier's phone no.:						
Claim no.:			Adjuster's name:									

NATURE OF INJURY												
Date of injury:				Time of injury:								
Please describe the accident in your own words:												
Last date worked:			Are you off work?		☐ Yes		☐ No					
Previous Workers' Compensation injury?		☐ Yes	☐ No	When?								
Accident reported to employer?		☐ Yes	☐ No	Name of person reported accident to:								
Injured at:			City:			State:		Zip:				
Length of time worked there prior to accident:												
Type of work being done at time of injury:												

YOUR MEDICAL HISTORY						
Have you been treated by another doctor for this accident?	☐ Yes	☐ No				
If yes, please list doctor's name and address:						
What type of treatment did you receive?						
How long were you treated by this doctor?						
Have/are you:	☐ Improved	☐ Unchanged	☐ Getting worse			
What types of medicine are you taking?						
Do these medicines help?	☐ Yes	☐ No	☐ I don't know			
Have you had physical therapy?	☐ Yes	☐ No	If yes, how often?			
☐ Daily	☐ Every other day	☐ Several times a week	☐ Weekly	☐ Every other week	☐ Monthly	☐ Other:
Does the physical therapy help?	☐ Yes	☐ No	☐ I don't know			
Prior to this accident, have you ever had any of the physical complaints similar to what you have now?						
☐ Yes	☐ No	☐ I don't know				
If yes, please describe:						
Were these similar complaints the results of a previous accident(s)?	☐ Yes	☐ No				
Please provide details of accident(s):						
Have you had any other serious accidents which required medical care?	☐ Yes	☐ No				
Describe:						
Have you had any serious illnesses that required hospitalization?	☐ Yes	☐ No				
Describe:						
Have you had any surgeries?	☐ Yes	☐ No				
If yes, please list type of surgery and date:						
Have you had any nervous or mental illnesses?	☐ Yes	☐ No				
Have you had psychiatric care?	☐ Yes	☐ No				
Have you received a medical discharge from the American Forces?	☐ Yes	☐ No				
Have you returned to work since this accident?	☐ Yes	☐ No				
If you have returned to work since your accident, please fill out the information below:						

Date:	Employer:	Occupation:	Light duty/ Reg. duty:	Full-time/Part-time:

CURRENT MEDICAL COMPLAINTS			
BACK PAIN:			
Currently, I have pain in my:	☐ Low back	☐ Mid back	☐ Upper back
My pain began:	☐ Gradually	☐ Suddenly	
I have pain:	☐ Sometimes	☐ All the time	
My pain goes into my:	☐ Right leg	☐ Left leg	☐ Both
I have tingling and/or numbness in my:	☐ Right leg	☐ Left leg	☐ Both
My pain gets worse when I:			
☐ Cough or sneeze	☐ Sit	☐ Bend	☐ Walk
☐ Lift	☐ Push	☐ Pull	☐ Stand
☐ Sleep	☐ Get up	☐ Go upstairs	☐ Other:
My back is worse with sexual activity:	☐ Yes	☐ No	
My pain wakes me up during the night:	☐ Yes	☐ No	
Changes in the weather affect my pain:	☐ Yes	☐ No	
NECK PAIN:			
My neck pain began:	☐ Gradually	☐ Suddenly	
I have pain:	☐ Sometimes	☐ All the time	
My pain goes into my:	☐ Right arm	☐ Left arm	☐ Both
My pain gets worse when I:			
☐ Cough or sneeze	☐ Bend forward	☐ Lift	☐ Push
☐ Pull	☐ Turn my head	☐ Sleep	☐ Other:
My pain wakes me up during the night:	☐ Yes	☐ No	
Changes in weather affect my pain:	☐ Yes	☐ No	
I have neck stiffness:	☐ Yes	☐ No	
I have headaches:	☐ Yes	☐ No	
If I do get headaches, they occur:	☐ Sometimes	☐ All the time	
OTHER PAIN			
Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional			
comments you wish to make regarding your condition:			

JOB DESCRIPTION									
(In terms of an 8-hour workday, “occasionally” means 33%, “frequently” means 34% to 66%, and “continuously” means 67% to 100% of the work day).									
In a typical 8-hour workday, I: (Check the number 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:				
Bend/ stoop	☐ Not at all	☐ Occasionally	☐ Frequently	☐ Continuously
Squat	☐ Not at all	☐ Occasionally	☐ Frequently	☐ Continuously
Crawl	☐ Not at all	☐ Occasionally	☐ Frequently	☐ Continuously
Climb	☐ Not at all	☐ Occasionally	☐ Frequently	☐ Continuously
Reach above shoulder level	☐ Not at all	☐ Occasionally	☐ Frequently	☐ Continuously
Crouch	☐ Not at all	☐ Occasionally	☐ Frequently	☐ Continuously
Kneel	☐ Not at all	☐ Occasionally	☐ Frequently	☐ Continuously
Balancing	☐ Not at all	☐ Occasionally	☐ Frequently	☐ Continuously
Pushing/ Pulling	☐ Not at all	☐ Occasionally	☐ Frequently	☐ Continuously
On the job, I lift:				
Up to 10 pounds	☐ Not at all	☐ Occasionally	☐ Frequently	☐ Continuously
11 to 24 pounds	☐ Not at all	☐ Occasionally	☐ Frequently	☐ Continuously
25 to 34 pounds	☐ Not at all	☐ Occasionally	☐ Frequently	☐ Continuously
35 to 50 pounds	☐ Not at all	☐ Occasionally	☐ Frequently	☐ Continuously
51 to 74 pounds	☐ Not at all	☐ Occasionally	☐ Frequently	☐ Continuously
75 to 100 pounds	☐ Not at all	☐ Occasionally	☐ Frequently	☐ Continuously
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:				
Right hand:				
Simple grasping:		☐ Yes	☐ No	
Firm grasping:		☐ Yes	☐ No	
Fine manipulating:		☐ Yes	☐ No	
Left hand:				
Simple grasping:		☐ Yes	☐ No	
Firm grasping:		☐ Yes	☐ No	
Fine manipulating:		☐ Yes	☐ No	
Are you required to work on unprotected heights?		☐ Yes	☐ No	
Describe:				
Are you required to be around moving machinery?		☐ Yes	☐ No	
Describe:				
Are you exposed to marked changes in temperature and humidity?		☐ Yes	☐ No	
Describe:				
Are you required to drive automotive equipment?		☐ Yes	☐ No	
Describe:				

Are you exposed to dust, fumes and gases?	☐ Yes	☐ No
Describe:		
Please list any additional comments:		

PATIENT SIGNATURE	
Signature:	Date: