Willoughby Chiropractic Center, Inc.

Dr. Patrick McLaughlin, D.C.

4040 Erie Str.
Willoughby, OH
44094

Ph: (440)-942-2225
Fax: (440) 942-0372

WORKER'S COMPENSATION HISTORY

Date: _____

Name: _____

Phone: _____

Address:

_____

_____

Age: _____ **Social Security Number:** _____

Injured Place of Employment: _____

Injured Place of Employment Address:

_____

_____

Injured Place of Employment's Phone Number: _____

Occupation: _____

Date of Injury: _____

Referred By: _____

History: **(describe accident)**

_____

_____

_____

_____

_____

If applicable, indicate any pain or abnormal sensations experienced immediately following the accident:

___Felt no immediate pain
___Head Pain
___Semi-conscience state
___Mid-back Pain
___Neck Pain
___ Low back Pain
___Other:

___Upper Extremity Pain
___Lower Extremity Pain
___Pain several hours later
___Pain shortly after accident
___ Saw Stars
___ Nausea/dizziness

_____

_____

_____

Indicate the action taken immediately following the accident:

___ **Went home and rested**
___ **Went about normal business**
___ **Went home and (shortly after/later that night/the following morning) began to experience (neck/mid-back/low-back) pain.**
___ **Went home and later (drove/was driven to_____ Hospital/Physician.**
___ **Doctored myself thinking the pain would go away**
___ **Went to Hospital/Physician**

Hospitalization: (IF NONE, SKIP TO TREATING PHYSICIANS NEXT PAGE)

Indicate method of transportation to hospital:

__ **Ambulance**
__ **Drove**
__ **Was driven**
__ **Went home and was later taken or driven to the hospital**

Name of hospital: _____ City:_____
Were you seen in the emergency room? Yes No
Were you admitted to the hospital? Yes No
Length of stay:_____
Name of admitting physician:_____
Indicate any procedures performed at the hospital (including emergency room) or other physician:

__ **Examination**	__ **Stitches**	__ **Cervical Collar**
__ **X-rays**	__ **Ice**	__ **Wounds Dressed**
__ **MRI/CT**	__ **Injection**	__ **Prescription**
__ **Complete Bed rest**	__ **Other _____**	

Following your release from the hospital you:

__ **Returned home and took it easy**
__ **Returned home and went to bed**
__ **Returned home and returned to the emergency room after ___ hrs/dys**
__ **Returned to work**

Treating Physicians:

When did you first consult a physician? _____
Name of physician?_____
Treatments/Medications from physician?_____
How long were you under the care of a doctor?:_____
Are you still being treated by a doctor? Y/N, if yes how often?_____
List any and all present treatments (meds, ice, heat, physical therapy, etc.)_____
_____

PAST HISTORY:

Have you ever been involved in any previous accidents or injuries, which caused the same or similar symptoms in the past? Y/N If yes, give dates and details:

_____

_____

_____

_____

Have you been treated for same or similar symptoms in the past? Please explain:

_____

_____

_____

List any past surgeries or conditions that could effect the present condition:

_____

_____

List any significant medical problems: (diabetes, heart, lungs, B/P, ect.)_____

_____

Did you enjoy good health prior to this accident? Y/N

List all activities that have been affected by your injuries due to the accident. Example (sports, social, and work activities, relationships, housework, etc.) Explain how they have been affected:

_____

_____

_____

PRESENT COMPLAINTS:

What are your present complaints, beginning with the most severe?
(circle one out of each group)

1. _____ **(constant/occasional) (mild/moderate/severe)**
2. _____ **(constant/occasional) (mild/moderate/severe)**
3. _____ **(constant/occasional) (mild/moderate/severe)**
4. _____ **(constant/occasional) (mild/moderate/severe)**

On a pain scale from 1 to 10 (one being mild and 10 being severe) how would you rate your overall condition? _____

Please CHECK all activities that are painful to perform:

__Sitting	__Standing	__Lying Down	__Movement	__Rest
__Use	__Walking	__Running	__Work Activities	__Housework

Symptoms are more noticeable:

__Morning	__Evening	__Afternoon	__Sleeping

DISABILITY:

Have you lost any time from work since the accident? Y/N If yes, how many days/weeks/months? _____

Are you still off from work? Y/N

If yes give estimated return to work date:

_____

Are you working with restrictions? Y/N If yes, list restrictions:

_____

_____

Additional Comments:

_____

_____

ADDITIONAL INFORMATION (if available)

ATTORNEY NAME: _____

ATTORNEY PHONE NUMBER: _____