

# WORK ACCIDENT INFORMATION

GRIMSLEY CHIROPRACTIC SERVICES, P.C.  
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## PATIENT INFORMATION

Patient Name \_\_\_\_\_ Date of Accident \_\_\_\_\_ Date: \_\_\_\_\_  
Time of Accident \_\_\_\_\_ [ ] a.m. [ ] p.m. Location \_\_\_\_\_  
Did You Report Your Injury to Your Foreman Or Employer? [ ] Yes [ ] No Name: \_\_\_\_\_  
Describe The Accident In Your Own Words: \_\_\_\_\_  
\_\_\_\_\_  
Were You Unconscious Immediately After The Accident? [ ] Yes [ ] No If Yes, For How Long? \_\_\_\_\_  
Where Did You Feel Pain Immediately After The Accident? \_\_\_\_\_  
Are You Still Employed By The Company Where The Injury Occurred? [ ] Yes [ ] No

## ACCIDENT INFORMATION

Location Name, Address, City & State Of Accident: \_\_\_\_\_  
Have You Had Previous Complaints In The Injured Area? \_\_\_\_\_ If Yes, When? \_\_\_\_\_  
Before The Injury, Were You Capable Of Working On An Equal Basis With Others Your Age? [ ] Yes [ ] No  
Have You Lost Any Days Of Work? [ ] Yes [ ] No If Yes; Date(s) \_\_\_\_\_  
Have You Ever Had An Accident Claim Before? [ ] Yes [ ] No If Yes; Explain: \_\_\_\_\_  
Did You Continue To Work After The Accident? [ ] Yes [ ] No Did Your Employer Recommend Care At Our Office? [ ] Yes [ ] No  
If Injured Before, Did You Lose Time From Work? [ ] Yes [ ] No If Yes; What Doctors Did You Consult? \_\_\_\_\_  
Do Any Other Diseases Or Accidents Affect Your Employment? [ ] Yes [ ] No If Yes; Explain \_\_\_\_\_  
With Your Job Duties, Do You Utilize Any Part Of Your Body In Excess Or To The Extent That You Are Unable To Since The Accident? \_\_\_\_\_

## TREATMENT

Did You Go To The Hospital ? [ ] Yes [ ] No If Yes, When: [ ] Immediately After The Accident [ ] The Next Day [ ] 2 or More Days  
How Did You Get To The Hospital? [ ] Ambulance [ ] Private Transportation  
Name Of Hospital: \_\_\_\_\_ Doctor's Name \_\_\_\_\_  
Treatment Received: \_\_\_\_\_ X-Ray's? [ ] Yes [ ] No  
Diagnosis: \_\_\_\_\_

## INSURANCE & ATTORNEY INFORMATION

Name Of The Insurance Responsible For Paying This Claim \_\_\_\_\_  
Name Of The Policy Holder: \_\_\_\_\_  
Policy #: \_\_\_\_\_ And / Or Claim #: \_\_\_\_\_  
Adjuster's Name: \_\_\_\_\_ Phone \_\_\_\_\_  
Have You Retained An Attorney? [ ] Yes [ ] No If Yes,  
Name \_\_\_\_\_  
Address \_\_\_\_\_ Phone: \_\_\_\_\_

## SYMPTOMS & INJURIES

Check Any Of The Following Symptoms You Have Had **Since The Accident**:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Arm/Shoulder Pain | <input type="checkbox"/> Feet/toe Numbness    | <input type="checkbox"/> Neck Pain           |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Hand/finger Numbness | <input type="checkbox"/> Neck Stiffness      |
| <input type="checkbox"/> Back Stiffness    | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Chest Pain        | <input type="checkbox"/> Irritability         | <input type="checkbox"/> Sleep Difficulty    |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Jaw Problems         | <input type="checkbox"/> Stomach Upset       |
| <input type="checkbox"/> Ear Buzzing       | <input type="checkbox"/> Leg Pain             | <input type="checkbox"/> Tension             |
| <input type="checkbox"/> Ear Ringing       | <input type="checkbox"/> Memory Loss          | <input type="checkbox"/> Vision Blurred      |
| <input type="checkbox"/> Fatigue           | <input type="checkbox"/> Nausea               |  |

Is This Condition Getting Worse?  Yes  No  Not Sure

Rate Your Pain On A Scale Of 1 (least pain) to 10 (most severe pain): \_\_\_\_\_

How Often Do You Get This Pain? \_\_\_\_\_ Is It Constant? \_\_\_\_\_

**Type Of Pain:**  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Stabbing  Other

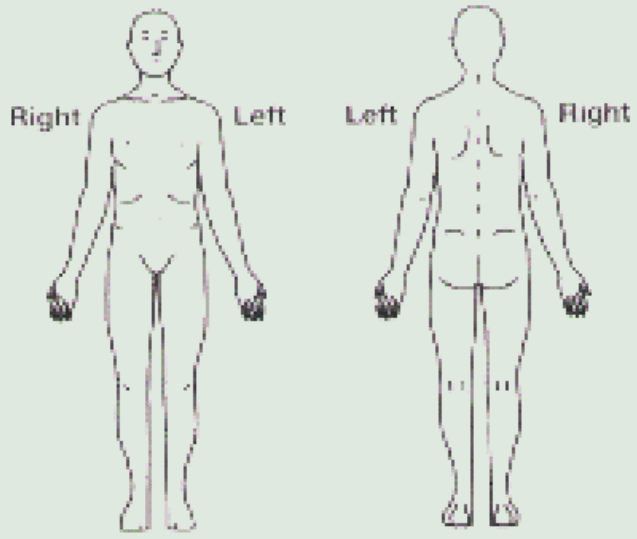
Does The Pain Interfere with Your:  Work  Daily Routine  Recreation

Activities That Are Painful To Perform:  Sitting  Standing  Walking  Bending  Lying Down

### PAIN DIAGRAM

Mark An "X" On The Diagram To The Right To Mark Your Areas Of Pain, Numbness or Tingling.

Note Any Concerns You Have Or Additional Symptoms You Are Having: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



To The Best Of My Knowledge The Above Information Is Complete & Correct. I Understand That It Is My Responsibility To Inform My Doctor If I, Or My Minor Child, Ever Have A Change In Health.

\_\_\_\_\_  
 Signature Of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Please Print Name Of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
 Relationship To Patient