Zindt Chiropractic Center
3819 S M St
Tacoma, WA 98418

Workmen's Compensation Information

Name______________________________ Date__________ Date of Birth__________
Last Name First Name Middle Initial

Employment Information

Employer's business name (at time of accident)______________________Phone #__________

Employer's Address____________________City__________State______ Zip________

Date that you reported this injury?________ Who did you report to?__________ What is their position?________

Name of Compensation Carrier______________________________ Phone #__________

Address of Carrier____________________City__________State______ Zip________

Were there any witnesses? YES / NO If yes, who______________ What is their position?__________

Following the Accident

Were you hospitalized as a result of this accident? YES / NO If yes, when?______________________

Name of Hospital____________________ Name of Doctor______________________

Were you examined? YES / NO Were X-rays taken? YES / NO Did you have an MRI or CT-scan? YES / NO (yes, circle which)

Did you receive treatment? YES / NO Treatment received______________________________

What benefits did you receive from treatment?____________________ Date of last treatment________

What type of medications are you taking?____________________ Do they help? YES / NO / Don't Know

Have you seen any other Doctors? YES / NO If yes, who______________________________

Treatment(s) received____

Have you had physical therapy? YES / NO If yes, how often______________ Where______________

Comments:____

____

Current Medical Complaints

I have pain in my:	☐ **Neck** (check boxes below for neck pain)	☐ **Mid Back** ☐ **Low Back** (check boxes below for back pain)
My pain began:	☐ gradually ☐ suddenly	☐ gradually ☐ suddenly
I have pain:	☐ sometimes ☐ all the time	☐ sometimes ☐ all the time
My pain goes into my:	☐ right arm ☐ left arm ☐ both	☐ right leg ☐ left leg ☐ both
I have tingling/numbness in my:	☐ right arm ☐ left arm ☐ both	☐ right leg ☐ left leg ☐ both
My pain wakes me up at night:	☐ Yes ☐ No	☐ Yes ☐ No
Changes in weather affect my pain:	☐ Yes ☐ No	☐ Yes ☐ No
My pain is worse when I:	☐ cough ☐ sit ☐ bend ☐ push ☐ sneeze ☐ lift ☐ walk ☐ pull	☐ cough ☐ bend ☐ lift ☐ sneeze ☐ drive ☐ pull ☐ twist ☐ walk ☐ push ☐ climb stairs ☐ sit ☐ stand ☐ go from sitting to standing position
I have neck stiffness:	☐ Yes ☐ No	
I have headaches:	☐ Yes ☐ No	

__________**Patient Initials**

Prior Similar Symptoms

Prior to this accident, have you ever had any of the physical complaints similar to what you have now? YES / NO / Unsure

If yes, describe________________________________

Have you ever had any **prior** injuries, accidents, diseases, or treatments to the area of your body now affected? YES / NO

If yes, describe________________________________

Were you treated? YES / NO If yes, who treated you________________ Treatment received________________

When was the last time you felt pain/had problems from that injury________________

Functional Assessment

Please indicate your ability to perform the following activities:

Activity				
Bending:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Carrying Groceries:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Dressing self:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Driving:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Extended computer use:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Household Chores:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Lifting:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Reading/Concentration:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Self Care:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Sitting:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Sleeping:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Walking:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Yard Work:	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable
Recreation (golf, bowling, etc.):	☐ Normal	☐ Limited/Difficult	☐ Painful	☐ Unable

Describe any current activity limitations:________________________________

Job Description

In a typical 8-hour workday, I: (circle the # of hours for each 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
___________:	1	2	3	4	5	6	7	8	hours

On the job I lift:	Never	Occasionally	Frequently	Continuously
0 – 10 lbs				
11 – 24 lbs				
25 – 34 lbs				
35 – 50 lbs				
51 – 74 lbs				
75 – 100 lbs				

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:

	Simple Grasping	Firm Grasping	Fine Manipulating
Right Hand	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Left Hand	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

On the job I:	Never	Occasionally	Frequently	Continuously
Bend / Stoop				
Squat				
Crawl				
Climb				
Crouch				
Kneel				
Balance				
Push / Pull				
Reach Overhead				

____________**Patient Initials**

Personal Health History

Are you currently under the care of a Healthcare Provider or any other Doctor? YES / NO

If yes, for what condition(s)____

____

Provider's Name______________________________ Phone____________________

Name of previous Chiropractor____

Date of Last: Chiropractic Exam____________ Spinal X-ray____________ EMG ____________

Cortisone Epidural________________ CT-Scan____________ MRI____________

Place an "X" to indicate if you have had any of the following:

☐ Headaches	☐ Irritable Bowel Syndrome	☐ Difficulty Walking
☐ Sinus Problems	☐ Liver Trouble/Hepatitis	☐ Skin Problems
☐ Dizziness	☐ Kidney Problems	☐ Easy Bruising
☐ Neck Pain	☐ Difficulty Urinating	☐ Anxiety
☐ Thyroid Problems	☐ Prostate Problems	☐ Depression
☐ Shoulder/Arm Pain	☐ Menstrual Problems	☐ Unexplained Fatigue
☐ Ear Problems	☐ Pelvic Pain	☐ Jaw Problems
☐ Asthma	☐ Heart Problems	☐ Arthritis, type:____________
☐ Throat Problems	☐ Poor Circulation	☐ Chronic Cough/Cold
☐ Difficulty Breathing	☐ Stomach Trouble	☐ Osteoporosis
☐ Mid Back/Rib Pain	☐ Colon Trouble	☐ Diabetes Type I or II
☐ Chest Pain	☐ Diverticulitis	☐ Hypertension/High Blood Pressure
☐ Wrist/Elbow/Hand Pain	☐ Stroke	☐ Cancer, type:____________
☐ Low Back Pain	☐ Knee Pain	☐ Glasses/Contacts
☐ Scoliosis	☐ Ankle/Foot Pain	☐ Frequent Infections
☐ Hip/Leg Problems	☐ Sciatica	

Other condition, please specify:____

____

Are you pregnant? YES / NO Due Date________________

Injuries / Surgeries you have had:	Description	Date
Falls	____________________	____________
Head Injuries	____________________	____________
Broken Bones	____________________	____________
Dislocations	____________________	____________
Surgeries	____________________	____________
Infections	____________________	____________

Have you ever:

Lost Consciousness	____________________	____________
Had Mental/Emotional Disorders	____________________	____________
Been Treated for a Spine/Nerve Disorder	____________________	____________

____________**Patient Initials**

Social History

Work Activity: What job did you do during most of your life?_______________

Diet/Nutrition: Are you on any special diet? YES / NO If yes, for what reason?_______________

Have you gained or lost over 10 pounds in the past 6 months without wanting to? YES / NO

How many caffeine drinks do you drink a day? (soda, coffee, tea, energy drinks) _______________

Habits: Tobacco Use: Now? YES / NO Amount/Weekly_________ How Long?________Years/Months

In the Past? YES / NO Amount/Weekly_________ How Long?________Years/Months

Smoking / Chewing Tobacco

Alcohol Use: Now? YES / NO Amount/Weekly_________ How Long?________Years/Months

In the Past? YES / NO Amount/Weekly_________ How Long?________Years/Months

Do you have any concerns regarding domestic or sexual abuse? YES / NO

Medications

☐Blood Pressure ☐Diabetic Meds.
☐Birth Control ☐Steroids
☐Muscle Relaxant ☐Antibiotics
☐Antidepressant ☐Anti-anxiety
☐Pain Medication ☐Heart Meds.
☐Cholesterol Meds. ☐Thyroid Meds.

Please list all medications that you are currently taking and major allergies:

☐_______________
☐_______________
☐_______________
☐_______________
☐_______________
☐_______________

Family History

Relation	Living	Deceased	Age (now or at death)	Serious Illness/Cause of Death
Mother				
Father				
Sister(s)				
Brother(s)				
Daughter(s)				
Son(s)				

Do you have any additional concerns at this time?_______________

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____

All the answers I have given are correct to the best of my knowledge, and I agree to continue with my chiropractic evaluation at Zindt Chiropractic Center at this time.

Patient's Signature _______________ Date_______________

Signature of Parent/Guardian_______________ Relationship_______________

_____________**Patient Initials**

_______________**Patient Initials**