StoneRidge Chiropractic

107 South 1470 East Suite 102 St. George, UT 84790 Phone 435-652-4476 Fax 435-674-2408

Justin W. Salmon, DC - Brian T. Richey, DC - T. Brock Kesterson, DC

WORKERS COMPENSATION HISTORY

Date of Intake:		SS No.:	
Last Name:		Gender:	Martial Status:
First Name:	MI:	☐ Male	☐ Single ☐ Divorced
Birth Date:	Age:	☐ Female	☐ Married ☐ Widowed
Address/City/State:		Telephone: (H)	(W)
Employer:		Occupation:	
Employer Phone:	Insurance Co.		
Insurance Contact Info:			
Date if Injury: (Specific)	(CT.)	Length of Employment:	
Current work status:			

JOB DESCRIPTION

Describe your duties at the time of your injury:

How many **hours** of the day were spent doing the following: Sitting: Standing:

Driving Time: Hrs. - Freq.: Gripping: Lbs. - Freq.:

What was the heaviest weight you had to lift? Name of item:

Distance carried:

Regular requirements?	0-10	11-25	26-50	51-75	76-100	100+ lbs
Lifting Capacity:	☐	☐	☐	☐	☐	☐
Floor-Waist:	☐	☐	☐	☐	☐	☐
Waist-Shoulder:	☐	☐	☐	☐	☐	☐
Overhead:	☐	☐	☐	☐	☐	☐
Carrying:	☐	☐	☐	☐	☐	☐

Repetitive Motion

Hands used repetitively? Freq.:

Feet used repetitively? Freq.:

Patient Pain Level:

☐ 0 = None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 = Unbearable

Do you smoke? ☐ Yes ☐ No Packs per day? For: Years

Do you drink alcohol? ☐ Yes ☐ No Drinks per week?

HISTORY OF INJURY

How did the accident happen?

What parts of your body were injured? **1** **2** **3** **4**

Initial symptoms:

Stop working? ☐ Yes ☐ No When:

Report injury to Supervisor: ☐ Yes ☐ No When:

Initial Medical care: When: Where:

Referred By: Doctor's Name & Specialty:

What was done on the initial visit? (Exam, X-ray, Special Tests, Meds, etc.):

Type of Treatment/Therapy:

Frequency/Length: Effectiveness:

Subsequent treatments (including all Doctors and testing)

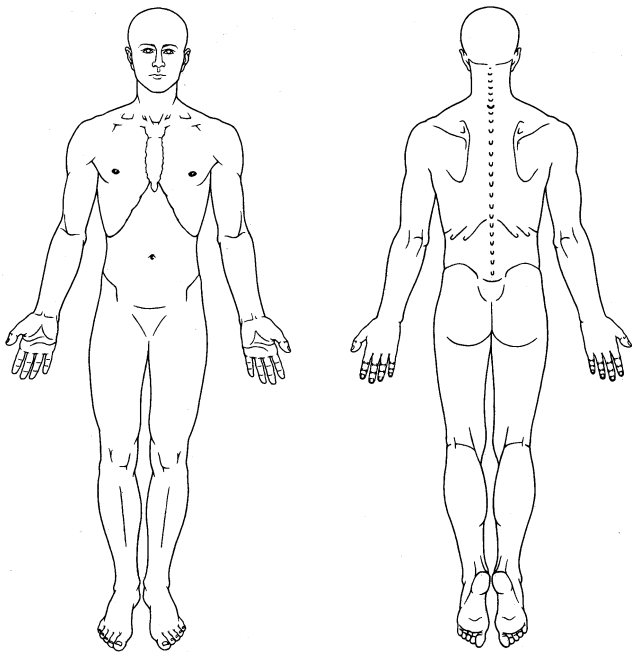
DISABILITY STATUS

Have you returned to work since the injury? ☐ Yes ☐ No When:

With same employer? ☐ Yes ☐ No Restricted or regular duty:

Did you receive Disability? (State Disability or Worker's Comp.)?

Do you hurt to perform your job?



CURRENT COMPLAINTS

1

2

3

4

PAST MEDICAL HISTORY

Prior injuries: Motor Vehicle:

Work:

Sports:

Other:

Major surgeries:

Hospitalizations:

Major illnesses: ☐ Hypertension ☐ Heart Disease ☐ Diabetes ☐ Ulcers ☐ Cancer

☐ Lung Conditions ☐ Kidney Problems ☐ Hernia ☐ Tuberculosis

☐ Other:

Family history of any of the above conditions? (Who/Which)

Allergies:

Current Medications: