

WORK INJURY HISTORY UPDATE

Name _____ Soc. Sec.# _____ D.O.B. _____
 Address _____ City _____ State _____ Zip _____
 Phone: Home _____ Work _____ Ext. _____ Cell _____
 For text msg reminders, list service provider: _____ Email _____
 Employer: _____ Emergency Contact _____ Ph. # _____
 Any change in Marital Status? Yes No If Yes circle one: Married Divorced Widowed Separated
 Insurance Co.: _____ Subscriber _____ Sub. D.O.B. _____
 For Pennsylvania accidents only: Does your employer have a **posted** panel of work-injury physicians? Yes No
 If **Yes**, is a chiropractor **other than** Dr. Richard D. Myers listed? Yes No If yes, please notify a staff person at once.

1. List present complaints (describe fully): _____

Constant Comes & Goes Dull Sharp Sore Stabbing Aches Burning Numb Stiffness

2. Date of Accident : _____ Describe how you were injured: _____

3. Did you report you injury? Yes No When did you report the injury? _____

4. Symptoms are worse when? Standing Bending Turning Lifting Walking Running Sleeping
 Looking Up / Down Working Overhead Coughing / Sneezing Sitting Driving Housework
 Other _____

5. Symptoms are better with? Lying down Sitting Standing Bending Legs up in a recliner Activity
 Heat Ice Pain medication _____ Other _____

6. Previous treatment before today for **this injury**: No prior treatment _____

7. Are you still working? Yes No If no, when did you last work? _____

8. If still working, are you working fewer hours because of the injury? Yes No How many hours currently? _____

9. Describe your occupation: _____ How do you rate your work activity?(check below)
 Seated more than 50% of workday Light Manual Labor Moderate Manual Labor Heavy Manual Labor

10. List current medications: _____

11. Family doctor: _____ Date of last physical: _____

12. Other information the doctor should know regarding this condition: _____

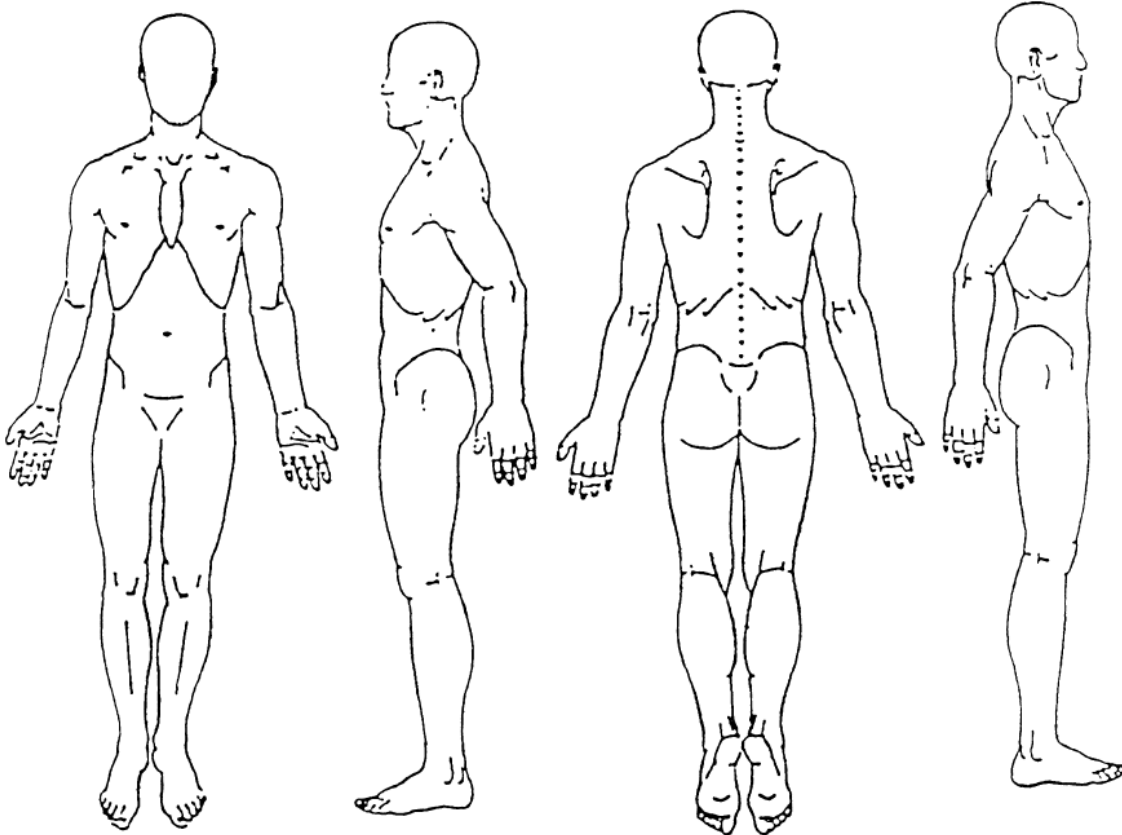
_____/_____/_____
Patient signature / Date / Account #

Doctor's Notes: _____

PAIN DRAWING

Using the following descriptive symbols, draw the location of your pain on the body outlines below

Ache ~~~~~ ~~~~~	Burning ===== =====	Numbness 000000 000000	Pins & Needles	Stabbing /////////////// ///////////////	Other XXXXXX XXXXXX
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CIRCLE THE PAIN LEVEL THAT BEST DESCRIBES YOUR CURRENT SYMPTOMS:

- | | |
|----------------------|-----------------------------------|
| 0 = NONE | 6 = MODERATE TO SEVERE |
| 1 = MINIMAL | 7 = MILDLY SEVERE, RESTRICTS SOME |
| 2 = VERY MILD | ACTIVITY |
| 3 = MILD | 8 = SEVERE, LIMITS MOST ACTIVITY |
| 4 = MILD TO MODERATE | 9 = VERY SEVERE |
| 5 = MODERATE | 10 = SUICIDAL, UNBEARABLE PAIN |

_____/_____/_____ Patient signature
_____/_____ Date
_____/_____ Account #