Southtowns Chiropractic, PLLC

Dr. Scott Przybyla
Dr. James Dossett
3445 Orchard Park Rd • Orchard Park, NY 14127
Tel: 716.674.0821 • Fax: 716.674.0293

Employment Accident History

Has injury been reported? · Yes · No Has care been authorized? · Yes · No

Employer's insurance: _____ Policy #: _____ Group #: _____ Claim #:_____

Employer's Name: _____ Currently an employee? · Yes · No

Phone: _____ Employer Address/City/State: _____

Is there an attorney involved? · Yes · No Firm: _____ Name: _____

Phone: _____ Address/City/ State: _____

Date and time of accident/injury: _____ · Gradual · Sudden · Progressive

Address/location where you were injured: _____

In your own words, please describe the accident: _____

_____

Did you lose consciousness during the accident? · Yes · No If yes, for how long? _____

Have you gone to a hospital or seen any other doctor? · Yes · No

- When did you go? Just after accident · Next day · 2+ days

- Describe any treatment you received? _____

- Are you *currently* receiving any type of care? · Yes · No

If yes, please describe: _____

Have you been able to work since this injury? · Yes · No

Are your work activities restricted as a result of this injury? · Yes · No

- Is there any activity or duty you are unable or find difficult to perform, please describe: _____

_____

- Are you wearing any type of brace or support? · Yes · No

Describe your routine job duties: _____

How often does your job require you do the following:

- Lifting (_____ lbs)
- Sitting (_____ hrs/day)
- Standing (_____ hrs/day)
- Computer (_____ hrs/day)
- Telephone (_____ hrs/day)
- Driving (_____ hrs/day)
- Push/pull: · 25% · 50% · 75% · 90-100% of the time.
- Reach overhead: · 25% · 50% · 75% · 90-100% of the time.
- Grasping: · 25% · 50% · 75% · 90-100% of the time.
- Twisting/bending: · 25% · 50% · 75% · 90-100% of the time.
- Squatting/kneeling: · 25% · 50% · 75% · 90-100% of the time.
- Walking: · 25% · 50% · 75% · 90-100% of the time.
- Climbing: · 25% · 50% · 75% · 90-100% of the time.
- Other - Please explain:_____

_____

Indicate the symptoms that are a result of this accident:

- Dizziness
- Memory loss
- Headaches
- Blurred vision
- Buzzing in ear
- Ears ringing
- Neck Pain
- Difficulty Sleeping
- Irritability
- Fatigue
- Tension
- Stiff Neck
- Jaw Problems
- Arm/shoulder pain
- Numbness/Tingling
- Chest Pain
- Shortness of breath
- Stomach upset
- Nausea
- Back Pain
- Lower back pain
- Back stiffness
- Leg Pain
- Other:

OVER *OVER*

Have you ever been injured at work prior to this accident/injury? · Yes · No

If yes, please explain: _____

Were you determined to have any permanent impairment/disability? · Yes · No

To the best of your knowledge, has this accident occurred in your workplace before? · Yes · No

Did you have any physical complaints BEFORE the accident? · Yes · No

Is your condition getting worse? · Yes · No · Constant · Comes and goes

I understand the above information and guarantee the forms completed today were completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Printed Name: _____ Signature: _____ Date: _____