SIGNAL HILL CHIROPRACTIC CENTER, INC.
CONFIDENTIAL PATIENT HISTORY Date ____________________
WORKER'S COMP HISTORY

Name____ Home Phone (   )______________________________
Cell Phone (   )________________________________ Pager (   )___________________________________
Address______________________________________ City_________________ State_________ Zip_________
Age________ Birth Date_____________________ Social Security #____________________________________
Marital Status: M S W D How Many Children______________________________

Employer____ Occupation______________________________
Address___________________________________ City________________ State____________ Zip__________
County____________________________________ Work Phone (   )_________________________________

Name of Spouse______________________________ Spouse SS#___________________________________
Spouse's Employer______________________________ Work Phone (   )____________________________
Address____

Name of Emergency Contact_________________________________ Phone (   )________________________
(Nearest relative not living in your home.)

How do you prefer to be addressed?____

Referred By:____

FAMILY DR./PRIMARY CARE PHYSICIAN:____

We will be keeping your family doctor or referring doctor informed regarding your care at this office by sending them office notes.

Please specify name and address. ____
____
____

PRESENT COMPLAINT: ____
____

DATE INJURED____________________ Hour_____________ AM/PM Last Day Worked_______________
Are you off work? ( ) Yes ( ) No Date Reported Accident____________________________________
Name of Person Reported Accident to ____
Accident Location ____
(street, city, state, zip)
Length of time with employer prior to injury: years_____________________ months________________
Type of work being done at time of injury ____

IN YOUR OWN WORDS PLEASE DESCRIBE ACCIDENT and IF ACCIDENT INVOLVED LIFTING/MOVING OBJECT PLEASE GIVE APPROXIMATE WEIGHT AND SIZE AND IF LIFTING STATE FROM/TO: (example: I bent over to lift a 25 lb. piece of steel from the floor to place in machine which was at waist level). ____
____
____
____

Prior to this accident have you ever had any of the physical complaints similar to what you have now?
( ) Yes ( ) No ( ) Don't Know If yes, describe ______________________________
____

Were these similar complaints the result of a previous accident(s)? ( ) Yes ( ) No Please provide details of accident(s)____
____

Have you consulted an attorney? ( ) Yes ( ) No If yes, list name, address and phone number:
____

How intense is the pain? ( ) Mild/dull ( ) Moderate ( ) Severe/Excrutiating/Agonizing
Please describe the character of your current pain. You may check one or more answers.
( ) Sharp/stabbing ( ) Burning ( ) Shooting ( ) Aches ( ) Soreness ( ) Weakness
( ) Throbbing/Gnawing ( ) Numbness ( ) Dull ( ) Gripping/Constricting ( ) Other__________

How often are the complaints present? ( ) Constant/100% of the time ( ) Frequent/75%
( ) Intermittent/50% ( ) Occasional/25%

Is the pain: ( ) Increasing ( ) Decreasing ( ) Not Changing

Pain is aggravated by: ( ) Walking ( ) Sitting ( ) Standing ( ) Riding in Car ( ) Lifting
( ) Bending ( )Stretching ( )Twisting ( ) Other____

Are your complaints affecting your ability to work or be active? ( ) No Effect ( ) Some Physical Restrictions ( ) Unable to perform regular duties

Are your complaints affecting your ability to sleep? ( ) Yes ( ) No

Have you missed any days of work or school? ( ) Yes ( ) No
Dates missed:____

Have you <u>ever</u> broken any bones? ( ) Yes ( ) No ____

Have you been in the hospital or had surgery for your present complaint? ( ) Yes ( ) No____________
____

Have you ever been in the hospital or had surgery for any other reason? ( ) Yes ( ) No
Please explain ____
____

What medications or Drugs are you taking?
Nerve Pills_____ Pain Killers_____ Muscle Relaxers _____ Blood Pressure Medication_____
Insulin_____ Birth Control Pill_____ Tranquilizers_____ Diet Pills_____ Anti-Inflammatory_____
Any non-prescription medication?
Tylenol_____ Ibuprofen_____ Aspirin_____ Other____

Do you smoke? ( ) Yes ( ) No

What is you exercise routine?____
____

Other Health Concerns:____