

DAY CHIROPRACTIC CLINIC, P.S.

2721 E Sprague Ave Spokane, WA 99202
Phone (509) 535-3038 Fax (509) 535-9749

John W. Day, D.C. Timothy J. Day, D.C. Stephen F. Renner, D.C. Wayne M. Fichter Jr, D.C.

WORK/COMP HISTORY

Name: _____ Date of Accident _____ Claim No: _____

1. Name of employer at time of accident: _____

2. Length of time worked there prior to accident: _____

3. Type of work being done at time of injury: _____

4. In your own words, please describe accident: _____

5. Have you been treated by another doctor for this accident? Yes No

If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____

How long were you treated by this doctor? _____

6. Are you: improved unchanged getting worse

7. What types of medications are you taking? _____

Do these medications help? Yes No Don't know

8. Have you had physical therapy? Yes No If yes, how often?

Daily Every other day Several time a week Weekly Every other week Monthly

Other _____

Does the physical therapy help? Yes No Don't know

9. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?

Yes No Don't know

Patient Name _____ Claim Number _____

If yes, please describe: _____

Were these similar complaints the results of a previous accident(s)? Yes No

Please provide details of accident(s): _____

10. Have you had any other serious accidents which required medical care? Yes No

11. Have you had any serious illnesses that required hospitalization? Yes No

Describe: _____

12. Have you had any surgeries? Yes No

If yes, list type of surgery and date: _____

13. Have you had any nervous or mental illnesses? Yes No

Have you had psychiatric care? Yes No

14. Have you received a medical discharge from the Armed Forces? Yes No

15. Have you returned to work since this accident? Yes No

If you have returned to work since your accident, please fill out the information below:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY REG. DUTY	FULL TIME PART TIME

CURRENT MEDICAL COMPLAINTS

BACK PAIN:

1. Currently, I have in my low back mid back upper back
2. My pain began: gradually suddenly
3. I have pain: sometimes all the time
4. My pain goes into my: right leg left leg both
5. I have tingling and/or numbness in my: right leg left leg both
6. My pain is worse when I:
 - cough or sneeze Yes No
 - sit Yes No
 - bend Yes No
 - walk Yes No
 - lift Yes No
 - push Yes No
 - pull Yes No
7. My back is worse with sexual activity Yes No
8. My pain wakes me up during the night Yes No
9. Changes in the weather affect my pain Yes No

NECK PAIN:

1. My neck pain began: gradually suddenly
2. I have pain: sometimes all the time
3. My pain goes into my: right arm left arm both
4. I have tingling and/or numbness in my right arm left arm both
5. My pain is worse when I:
 - cough or sneeze Yes No
 - bend forward Yes No
 - lift Yes No
 - push Yes No
 - pull Yes No
 - turn my head Yes No

Patient Name _____ Claim Number _____

- 6. My pain wakes me up during the night Yes No
- 7. Changes in the weather affect my pain Yes No
- 8. I have neck stiffness Yes No
- 9. I have headaches Yes No
- 10. If I do get headaches, they occur: Sometimes All the time

OTHER PAIN:

Please describe any current medical complaints which you are experiencing and were not previously covered on this Questionnaire, or list any additional comments you wish to make regarding your condition:

JOB DESCRIPTION:

(In terms of an 8-hour workday, "occasionally" means 33 %, "frequently" means 34 % to 66 %, and "continuously" means 67 % to 100 % of the day).

1. In a typical 8-hour workday, I: (Circle # of hours / 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

2. On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend / stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing / Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. On the job, I lift:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Up to 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 to 24 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25 to 34 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35 to 50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 to 74 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75 to 100 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 4. Do you have to bend over while doing any lifting? Yes No
- 5. Are your feet used for repetitive movements, such as in operating foot controls? Yes No

Patient Name _____ Claim Number _____

6. Do you use your hands for repetitive actions, such as:

	SIMPLE GRASPING	FIRM GRASPING	FINE MANIPULATING
Right hand	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Left hand	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

7. Are you required to work on unprotected heights? Yes No

Describe: _____

8. Are you required to be around moving machinery? Yes No

Describe: _____

9. Are you exposed to marked changes in temperature and humidity? Yes No

Describe: _____

10. Are you required to drive automotive equipment? Yes No

Describe: _____

11. Are you exposed to dust, fumes and/or gases? Yes No

Describe: _____

12. Please list any additional comments: _____

Patient Signature: _____ Date: _____

Print Name: _____