

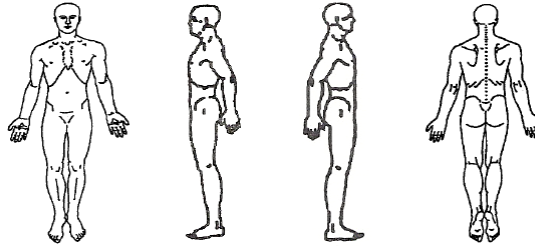
Worker's Compensation Information

Name: _____ Date: _____

Date & Place of Injury: _____

Type of Injury: _____

Location of Injury: (please circle on diagrams)



How did the Injury occur? _____

Did you see the Injury coming? No Yes

If yes, did you brace yourself in any way? No Yes

How were you positioned? Standing Seated
 Bending Stooping
 Facing Forward Body Turned Left
 Body Turned Right Head Turned Left
 Head Turned Right Other _____

Did you seek medical attention? No Yes

If yes, Date & Location: _____

Name of Doctor: _____

Did they take X-rays? No Yes

Were you Hospitalized? No Yes, How long? _____

Diagnosis: _____

Instructions / Medications given to you: _____

Did you report the Injury to your supervisor? No Yes

What is the name of the company? _____

Contact Person: _____

Phone Number for Verification: _____

Claim Number: _____

Please give any additional details of the accident: _____

What is your reason(s) for seeking treatment? _____

Please give any symptoms you've had since the accident: (check all that apply)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> headache | <input type="checkbox"/> neck pain | <input type="checkbox"/> upper-back pain | <input type="checkbox"/> middle-back pain |
| <input type="checkbox"/> lower-back pain | <input type="checkbox"/> pelvic pain | <input type="checkbox"/> stiffness | <input type="checkbox"/> tension |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> light-headedness | <input type="checkbox"/> dizziness | <input type="checkbox"/> fainting / black outs |
| <input type="checkbox"/> nausea | <input type="checkbox"/> irritability | <input type="checkbox"/> nervousness | <input type="checkbox"/> sleeping problems |
| <input type="checkbox"/> depression | <input type="checkbox"/> loss of smell | <input type="checkbox"/> loss of taste | <input type="checkbox"/> loss of sensation |
| <input type="checkbox"/> light sensitivity | <input type="checkbox"/> blurred vision | <input type="checkbox"/> sinus problems | <input type="checkbox"/> ringing in ears |
| <input type="checkbox"/> buzzing in ears | <input type="checkbox"/> jaw problems | <input type="checkbox"/> loss of memory | <input type="checkbox"/> loss of concentration |
| <input type="checkbox"/> face flushed | <input type="checkbox"/> loss of balance | <input type="checkbox"/> diarrhea | <input type="checkbox"/> constipation |
| <input type="checkbox"/> upset stomach | <input type="checkbox"/> cold sweats | <input type="checkbox"/> fever | <input type="checkbox"/> breathing problems |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> joint pain | <input type="checkbox"/> extremity pain | <input type="checkbox"/> loss of strength |
| <input type="checkbox"/> cold feet | <input type="checkbox"/> cold hands | <input type="checkbox"/> finger / hand numbness | <input type="checkbox"/> toe / foot numbness |
| <input type="checkbox"/> pins & needles sensation in arms / hands | <input type="checkbox"/> pins & needles sensation in legs / feet | | |

Please list any other symptoms, not mentioned above, that you have noticed since the accident:

How has your life been affected since the accident? Not at all Some A Lot

Have you lost any days of work because of this? No Yes, How much? _____

Since the accident, have you had trouble with any of the following: (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Getting ready for the day | <input type="checkbox"/> Getting ready for bed |
| <input type="checkbox"/> Driving | <input type="checkbox"/> Household chores |
| <input type="checkbox"/> Work / School activities | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Other _____ | |

Did you hire an Attorney? No Yes, Name: _____

Who do we send the claims to? _____

Contact Information: _____

Contact Person: _____

I, _____, have answered the above questions to the best of my ability and do hereby acknowledge that the answers I have given are completely true. I do hereby authorize Active Spine & Rehabilitation to treat me for the stated injury and agree to comply with their management plan. If I do not comply with the recommended plan, I agree that Active Spine & Rehabilitation is not responsible for my outcome. I realize that I may never get back to my pre-accident condition and will be treated to a point of maximum improvement. I agree to be responsible for all charges, regardless of the outcome of my personal injury claim. In the event that the responsible party does not compensate Active Spine & Rehabilitation, I will pay for such charges. If a check is issued to me, I am responsible for paying Active Spine the amount owed. I do hereby authorize a doctor's lien in the event that my attorney receives my settlement.

I understand the above statements and agree to the terms by signing below.

Signature _____ Date _____

Printed Name _____

Parent / Guardian's Signature (if minor or legally unable to consent) _____

Doctor's Signature _____ Date _____