VALENTE
CHIROPRACTIC

Work Injury Form

Name: _____ **Today's Date:** _____ **DOB:** _____

Report of Incident:

Date of Injury:_____ / _____ /_____ Time of Injury:_____❑A.M. ❑P.M.
Was your accident directly related to your work? ❑Yes ❑No
Address of where the work injury occurred: _____
Did the incident render you unconscious? ❑Yes ❑No If yes, for how long?_____

Please explain the details of the work injury to the best of your knowledge: _____
_____
_____
_____
_____
_____

Was anyone present during your accident? ❑Yes ❑No
Did you report the accident to your employer? ❑Yes ❑No
What recommendations did your employer make just after your accident?
_____
Has this type of accident happened to you before? ❑Yes ❑No
To the best of your knowledge, has this accident occurred in your workplace before? ❑Yes ❑No

In general:
Is your job physically stressful? ….....❑Yes ❑No Is your job mentally stressful? ….....❑Yes ❑No
Is your workplace noisy? ….....❑Yes ❑No Have you changed jobs in the last year? ❑Yes ❑No

Insurance Information:

Employer: _____ Insurance Company:_____Telephone #: _____
Address:_____City: _____ State: _____ Zip: _____
Name of Claim Representative: _____ *Telephone #:* _____

Attorney Information:

Name of Attorney/Law Office: _____ Telephone #: _____
Address of Attorney:_____ City: _____ State: _____ Zip:_____

Work:

To evaluate the effect that continuing work will have on your recovery please complete the following:
Have you been able to work since the injury? ❑Yes ❑No

Are your work activities restricted as a result of your injuries sustained? ❑Yes ❑No

How many hours are in your normal work day? _____

What can you do for work with minimum physical effort and for how long? _____❑N/A

Prior to the injury were you capable of working on an equal basis with others your age? ❑Yes ❑No ❑N/A

While in recovery, is there any light duty work you could request? ❑Yes ❑No ❑N/A

Please indicate your daily job duties and any activities in which you are occasionally asked to perform:
❑Standing ❑Sitting
❑Walking ❑Lifting
❑Driving ❑Twisting
❑Crawling ❑Bending
❑Operating equipment ❑Working with arms above head
❑Typing ❑Stooping
❑Other: _____

Medical Care:

Have you gone to a Hospital or seen any other Doctor? ❑Yes ❑No
When did you go? ❑Just after accident ❑Next Day Other:_____
Mode of Transportation: ❑Ambulance ❑Privately transported
Name of Hospital and/or Attending Doctor:_____
_____

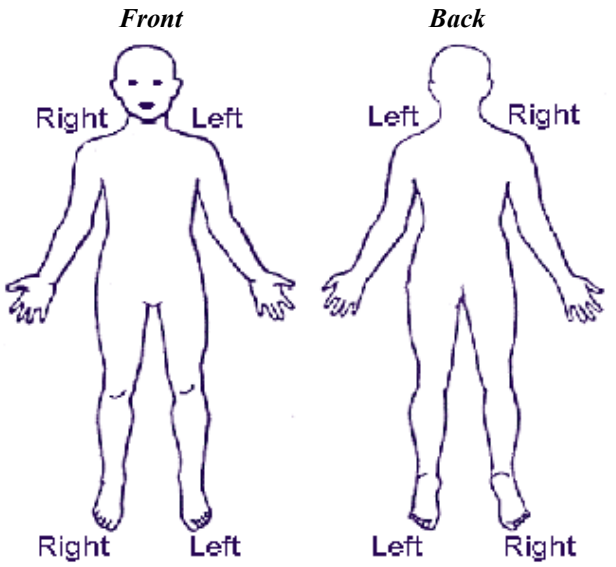
Were X-Rays taken? ❑Yes ❑No
If yes, what : _____
Describe any treatment you received: _____
_____

Pain Intensity Prior to the Incident / Injury

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

Today's Pain Intensity

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain



On the image please indicate where you are experiencing your symptoms.

Since the Date of Injury on: _____

How would you describe the character of your condition/pain?
(please check all that apply)

❑Sharp ❑Dull ❑Tingling ❑Numb
❑Aching ❑Shooting ❑Radiating ❑Burning
❑Throbbing ❑Cramping ❑Stiffness ❑Swelling
❑Other _____

Is your condition getting worse?
❑Yes ❑No ❑Constant ❑Comes & Goes

How often do you experience your symptoms?
❑ Constantly (76%-100% of the time)
❑ Frequently (51%-75% of the time)
❑ Occasionally (26%-50% of the time)
❑ Intermittently (0%-25% of the time)

When do you experience your symptoms?
Ex: every day, most days, some days, a few times a year

_____

	Comfortable	Uncomfortable	Painful
Lying on back	❑	❑	❑
Lying on side	❑	❑	❑
Lying on stomach	❑	❑	❑
Lovemaking	❑	❑	❑
Sports	❑	❑	❑
Working	❑	❑	❑
Sitting	❑	❑	❑
Standing	❑	❑	❑
Stretching	❑	❑	❑
Walking	❑	❑	❑
Running	❑	❑	❑
Bending	❑	❑	❑
Lifting	❑	❑	❑
Kneeling	❑	❑	❑
Pulling	❑	❑	❑
Reaching	❑	❑	❑
Standing from a seated position	❑	❑	❑
Other: _____	❑	❑	❑

What have you tried to help alleviate your condition?

_____

_____

Does your condition interfere with your....
❑Sleep ❑Work ❑Daily Routine
❑Recreational activities ❑Other: _____

Additional information / Any recent falls and/or injuries / Prior condition related medical history:

_____

_____

_____

_____

_____

_____

If you have been involved in previous accidents please list them:

_____

_____

_____

_____

Patient Signature: _____ **Today's Date:** _____