Affiinity Chiropractic LLC

Thank you for carefully answering each question!

Patient: Black ink,

Doctor: Red ink

Patient Name: _____ **Date:** _____

Work History (*Page 1*):

Employer Information:

Name of Employer: _____ **Occupation** _____

Employer Address: _____

State: _____ **Zip Code:** _____ **Work Phone:** _____

Date Injured: _____ **Time:** _____ **Last Day Worked:** _____

Accident Reported to employer? Yes ☐ No ☐ **Name of who you reported it to:** _____

Injury Location? _____

Type of work being done at time of Injury? _____

In your own words, please describe the accident? _____

_____

_____

Have you returned to work since the accident? No ☐ Yes ☐ Light Duty ☐ Reg. Duty ☐

Have you Been treated/seen by another doctor for this accident? Yes ☐ No ☐

If yes, Please list names and addresses: _____

_____

Please explain the type of treatment you received: _____

_____

How long have you been treated by these doctor/s? _____

Are you: Better ☐ Unchanged ☐ Don't Know ☐

Have you have physical therapy? Yes ☐ No ☐ **If yes, How often?** _____

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Confidential Patient Information & Agreement (*Page 2*):

Information Continued:

Prior to the accident, have you ever had any of the physical complaints similar to what you have now? Yes ☐ No ☐

If Yes: Were these similar complaints the result of a previous accident? Yes ☐ No ☐

If yes: Please describe the details of the accident: _____

_____

Have you had any other serious accidents that required medical attention? Yes ☐ No ☐

If yes: Please explain: _____

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

If yes: Please explain: _____

Have you had any surgeries? Yes ☐ No ☐**If yes, Please describe what and when:** _____

_____

Have you had any nervous or mental illness? Yes ☐ No ☐ **If yes, Please describe:** _____

_____

Have you have any psychiatric care? Yes ☐ No ☐

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

Back Pain:]

I currently have pain in my: Lower Back ☐ Mid Back ☐ Upper Back ☐

My pain began: Gradually ☐ Suddenly ☐ **I have pain:** All of the time ☐ Sometimes ☐

My pain goes into: Right leg ☐ Left leg ☐ Both ☐

I have tingling and/or numbness in my : Right leg ☐ Left leg ☐ Both ☐

My pain gets worse when I: Cough ☐ Sneeze ☐ Sit ☐ Bend ☐ Walk ☐ Lift ☐ Push ☐ Pull ☐

My Back gets worse with sexually activity? Yes ☐ No ☐

My pain wakes me up in the middle of the night? Yes ☐ No ☐

Confidential Patient Information & Agreement (*Page 3*):

Changes in the weather affect my pain? Yes ☐ No ☐

Neck Pain:

My Neck pain began: Gradually ☐ Suddenly ☐ **I have pain:** All of the time ☐ Sometimes ☐

My pain goes into: Right arm ☐ Left arm ☐ Both ☐

I have tingling and/or numbness in my : Right arm ☐ Left arm ☐ Both ☐

My pain gets worse when I: Cough ☐ Sneeze ☐ Sit ☐ Bend ☐ Walk ☐ Lift ☐ Push ☐ Pull ☐

My pain wakes me up in the middle of the night? Yes ☐ No ☐

Changes in the weather affect my pain? Yes ☐ No ☐

I have neck stiffness? Yes ☐ No ☐ **I have headaches?** Yes ☐ No ☐

If yes, headaches occur: All of the time ☐ Sometimes ☐

Other Pain:

Please explain any current medical complaints you are experiencing and were not previously covered on this questionnaire, or list any medical comments you would like to make regarding your condition: _____

_____

_____

Job Description:

In a typical 8-hour work day, I: (circle # of hours of 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

In a typical 8-hour work day, I perform the following: (circle frequency)

Confidential Patient Information & Agreement (*Page 4*):

Bend/Stoop: Not At All Sometimes All of the time

Squat: Not At All Sometimes All of the time

Crawl: Not At All Sometimes All of the time

Climb: Not At All Sometimes All of the time

Crouch: Not At All Sometimes All of the time

Kneel: Not At All Sometimes All of the time

Balance: Not At All Sometimes All of the time

Push/Pull: Not At All Sometimes All of the time

Reach above shoulder level: Not At All Sometimes All of the time

Lift: Not At All Sometimes All of the time

If any lifting, How much?

11 to 24 lbs 25 to 34 lbs 35 to 50 lbs 51 to 74 lbs 75 to 100 lbs +

Do you have to bend over while doing any lifting? Yes ☐ No ☐

Do you use your hands for any repetitive movements? Yes ☐ No ☐

If yes, circle any that apply: Simple Grasping Firm Grasping Fine Manipulating

Right Hand: Yes ☐ No ☐ **Left Hand:** Yes ☐ No ☐

Are you required to work on unprotected heights? Yes ☐ No ☐

If yes, please describe: _____

Are you required to work around moving machinery? Yes ☐ No ☐

If yes, please describe: _____

Are you exposed to marked changes in temperate and humidity? Yes ☐ No ☐

If yes, please describe: _____

Are you required to drive automotive equipment? Yes ☐ No ☐

If yes, please describe: _____

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Confidential Patient Information & Agreement (*Page 5*):

Are you exposed to any dust fumes or gases? Yes ☐ No ☐

If yes, please describe: _____

Please list any additional comments here about your job description: _____

_____

_____

_____

Thank you for taking the time to fill out this questionnaire. This information is important in the doctor obtaining a clinical picture so as to make an appropriate diagnosis & treatment plan. Please sign below authorizing that the information in this form has been read & filled out completely & accurately to the best of your understanding. Also, understand that the information in this form is considered confidential & for use by your doctor at Neurological Rehabilitation Center LLC. Any disclosure is outlined in our privacy policies.

Patient's signature (*or guardian's signature*) _____ Date _____

Patient's print (*or guardian's print name*) _____

Signature of translator or person assisting with this form (*if any)* _____

Printed name of said person _____ Date _____