

Cole Family Chiropractic

68 North High Street, Ste E-106, New Albany, OH 43054

(614) 855-5454 (p) ~ (614) 283-5400 (f)

WORKERS COMPENSATION HISTORY

Patient Name: _____

Employers Name: _____ Telephone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Carrier Name: _____ Telephone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Have you retained legal counsel for this injury? **Yes No**

If yes, give name and address: _____

Injury Description

Date present injury was received: _____ Time of injury: _____ **A.M P.M.** Overtime? **Yes No**

Who saw the accident? **Name** _____ **Title** _____

Who reported the accident? **Name** _____ **Title** _____

How did the injury occur? _____

If working on a machine, give description: _____

Do you use foot or hand levers? **Yes No** Do you work overhead? **Yes No**

Do you have to reach? **Yes No** Where? _____

Movements on the job: Do you move to your: **Right Left Up Down Under Over**

Do you pick up or lift? **Yes No** If yes, how much? _____ How often? _____

From where to where? _____

Do you lift from: **Ground Bench Platform Box Pallet Other:** (Please Describe) _____

Do you lift in and out of a machine? **Yes No** If working at a machine, do you? **Sit Stand Kneel**

Is your work area cluttered? **Yes No** If yes, with what? _____

Is your work area: **Oily Dirty Slippery Other**

In your job do you push or pull? **Yes No** If yes, give specifics: _____

Do you use a cart? **Yes No Two-wheel Four-wheel** Type of wheels: **Rubber Steel Plastic**

Condition of cart: **Good Bad Other** _____ Number of carts being pushed or pulled at once: _____

Total amount of weight being pushed or pulled on a daily basis: _____

Office Work

If your injury has occurred from office work only, please fill out the following:

I...: **Sit at desk** **Walk** **Stand** **Stoop** **Hold** **Carry** **Other** _____

Give percentage, if applicable: _____ Do you operate office machinery? **Yes** **No**

If yes, what type? _____

If your work is at a desk, give specifics of job, computer, typewriter, business machine, phone, etc.

If walking, where to and job classification: _____

Do you carry anything or pick anything up? **Yes** **No** If yes, what? _____

Previous Work History

Give a job description of services or work performed for each job classification or source of employment for the preceding 10 (ten) years.

1. _____
2. _____
3. _____
4. _____
5. _____

Was a pre-employment exam performed or required? **Yes** **No**

If so: **Date:** _____ **Doctor:** _____ **Place:** _____

Have you ever applied for Workers' Compensation benefits before? **Yes** **No** Date: _____

Reason: _____

Was there a time loss from work? **Yes** **No** **From:** _____ **To:** _____ **Year:** _____

State the degree of recovery: _____

Did you retain legal counsel for these injuries? **Yes** **No**

If yes, give name and address: _____

Present Work History

What is the job classification of your normal job? _____

Were you performing your normal job? **Yes** **No** What shift were you working? _____

How long have you been at your present job? _____

Has there been a time of loss or absenteeism caused from job injury? **Yes** **No**

If yes, please explain: _____

Average work week: _____ Hours: _____ Days: _____

Job Conditions

Type of building: _____

Type of floor: **Rough Smooth Wood Concrete Steel Other:** _____

Type of windows: **Open Closed No windows**

Type of ventilation in the building: **Blower A/C Heat Exhaust None Other:** _____

Type of lighting in the building: **Fluorescent Overhead On machine Other:** _____

Are you tired when you go home at night? **Yes No**

Do you have any outside jobs? **Yes No** If yes, what type? _____

Do you participate in any company-sponsored programs such as exercise, sports, etc? **Yes No**

If yes, please describe: _____

Type of shop: **Union Non-Union**

Has outside help been hired? **Yes No** If yes, why? _____

How many employees are in the plant? _____ How many employees per shift? _____

How many employees do your job? _____ What is the current injury ratio for that job? _____

How many employees have been injured doing your job? _____ Do you like your job? **Yes No**

If off work, do you want to return to your job? **Yes No**

What changes would you make in your job? _____

The above information is accurate and has been completed to the best of my knowledge:

Patient Signature

Date

Staff Signature

Date