

Patterson Chiropractic Clinic

Work Comp Injury Information

Patient Name: _____
Date of Accident: _____

Date: _____
Chart #: _____

If your injury involved Lifting, complete this section:

From where were you lifting an object?

Ground Level A surface below ground level
 A surface 1 to 3 Ft. High A surface 3 to 5 Ft. High

How many pounds was the object you were lifting?

1 to 5 pounds 5 to 10 pounds 10 to 20 pounds 20 to 40 pounds
 40 to 60 pounds Over 60 pounds

What position were you in while lifting the object?

Back was upright and straight Bent over at the waist
 Twisted to the left side Twisted to the right side

What type of pain did you feel immediately after the injury?

Gripping pain Sharp pain Dull pain Aches
 Popping feeling Paralysis

If your injury involved Falling, complete this section:

From where did you fall at work?

On to the ground while walking Onto the ground while running
 From 1 to 3 Ft. High From 3 to 5 Ft. High
 From 5 to 8 Ft. High From Higher than 8 Ft.

What part of your body did you land on?

Head Neck Right Shoulder Left Shoulder
 Right Arm Left Arm Right Hand Left Hand
 Back Right Buttock Left Buttock Tail Bone
 Right Hip Left Hip Right Leg Left Leg
 Right Knee Left Hip Right Foot Left Foot

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What other areas of your body were affected by your fall?

<input type="checkbox"/> Head	<input type="checkbox"/> Neck	<input type="checkbox"/> Right Shoulder	<input type="checkbox"/> Left Shoulder
<input type="checkbox"/> Right Arm	<input type="checkbox"/> Left Arm	<input type="checkbox"/> Right Hand	<input type="checkbox"/> Left Hand
<input type="checkbox"/> Back	<input type="checkbox"/> Right Buttock	<input type="checkbox"/> Left Buttock	<input type="checkbox"/> Tail Bone
<input type="checkbox"/> Right Hip	<input type="checkbox"/> Left Hip	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Left Leg
<input type="checkbox"/> Right Knee	<input type="checkbox"/> Left Hip	<input type="checkbox"/> Right Foot	<input type="checkbox"/> Left Foot

Other work related injuries:

<input type="checkbox"/> Raised Up from bending over	<input type="checkbox"/> Twisted at the waist
<input type="checkbox"/> Wrist Injury from Repetitive use	<input type="checkbox"/> Wrist injury from pulling

Job analysis information:

What regular activities did you perform at work?

<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Walking
<input type="checkbox"/> Running	<input type="checkbox"/> Driving	<input type="checkbox"/> Lifting
<input type="checkbox"/> Bending/Stooping	<input type="checkbox"/> Squatting	<input type="checkbox"/> Crawling
<input type="checkbox"/> Climbing	<input type="checkbox"/> Crouching	<input type="checkbox"/> Reaching above shoulders
<input type="checkbox"/> Kneeling	<input type="checkbox"/> Pushing/pulling	<input type="checkbox"/> Maintain Awkward Position

How much do you regularly lift at your job?

<input type="checkbox"/> Little to none	<input type="checkbox"/> 1 to 10 pounds	<input type="checkbox"/> 10 to 20 pounds	<input type="checkbox"/> 20 to 40 pounds
<input type="checkbox"/> 40 to 60 pounds	<input type="checkbox"/> 60 to 80 pounds	<input type="checkbox"/> 80 to 100 pounds	<input type="checkbox"/> over 100 pounds

Do you regularly bend over while lifting?

Yes No

Are your hands subject to any of the below repetitive movements?

<input type="checkbox"/> Light grasping	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Firm grasping	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
<input type="checkbox"/> Typing	<input type="checkbox"/> Using a computer mouse		

How many hours do you regularly perform the below activities?

Sitting	<input type="checkbox"/> 1-2 hrs.	<input type="checkbox"/> 2-4 hrs.	<input type="checkbox"/> 4-6 hrs.	<input type="checkbox"/> 6-8 hrs.
Standing	<input type="checkbox"/> 1-2 hrs.	<input type="checkbox"/> 2-4 hrs.	<input type="checkbox"/> 4-6 hrs.	<input type="checkbox"/> 6-8 hrs.
Walking	<input type="checkbox"/> 1-2 hrs.	<input type="checkbox"/> 2-4 hrs.	<input type="checkbox"/> 4-6 hrs.	<input type="checkbox"/> 6-8 hrs.
Lifting	<input type="checkbox"/> 1-2 hrs.	<input type="checkbox"/> 2-4 hrs.	<input type="checkbox"/> 4-6 hrs.	<input type="checkbox"/> 6-8 hrs.