Dwyer Chiropractic Center
1013 Bridge Street Suite D
Clarkston, WA 99403

Patient Information and Injury History Form

Patient Information Date: _____

Patient's Name : _____

Social Security Number : _____ DOB: _____

Insurance Information

Insurance Company : _____

Claim Number : _____

Address : _____

_____

Adjuster Name : _____

Insurance Company /Adjuster Phone: _____

Employer Information

Employer Name : _____

Employer Address: _____

_____

Work Phone : _____

Work Comp Information

Work Comp Company: _____

Claim Number : _____

Adjuster Name : _____

Adjuster Phone : _____

Attorney Information

Attorney Name: _____

Company if Different: _____

Address: _____

_____

Attorney Phone: _____

Date of Accident: _____ Time of Accident:

Date of First Treatment: _____

What state did injury happen: _____

What type of Injury:	Auto Accident
	Work Comp Injury
	Other Injury

History of Injury

In your own words, please briefly describe your injury, place, when, where, and any other detail pretaining to injury:

Previous Condition and Treatment

In your own words, please briefly list any previous medical conditions and treatment:

What areas are affected?

	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 Knee		Right Foot		Left Foot

Other work related injuries:

	Raised up from bending over		Twisted at the waist
	Wrist injury from repetitive use		Wrist injury from pulling

(please describe ALL injuries in your own words on page 1 of this form)

Job analysis information:

* What regular activities did you perform at work?

	Sitting		Standing		Walking
	Running		Driving		Lifting
	Bending		Squatting		Crawling
	Climbing		Crouching		Reaching
	Kneeling		Pushing/Pulling		Maintain awkward position

* How much do you regularly lift at your job?

	Little to none		1 to 10 Lbs		10 to 20 Lbs		20 to 40 Lbs
	40 to 60 Lbs		60 to 80 Lbs		80 to 100 Lbs		Over 100 Lbs

* Do you regularly bend over while lifting?

	Yes		No

* Are your hand subject to any of the below repetitive movement?

	Light grasping (left hand)		Firm grasping (left hand)
	Light Grasping (right hand)		Firm grasping (right hand)
	Light grasping (both hands)		Firm grasping (both hands)
	Typing		Using a computer mouse

* How many hours do you regularly perform the below activities?

	Sitting	Standing	Walking	Lifting
1-2 Hours				
2-4 Hours				
4-6 Hours				
6-8 Hours				
8+ Hours				