

IANNUCCILLI

CHIROPRACTIC

WORKER'S COMPENSATION ACCIDENT/INJURY INFORMATION

PATIENT INFORMATION

Today's Date: ___/___/___

Name: _____ SS#: _____
First Middle Last

Date of Birth: ___/___/___ Sex: Male Female

(if patient is under 18) Parent/Guardian Name: _____ Parent/Guardian Phone: _____

Address: _____
Street name Apt # City State Zip

Cell Phone: _____ Email: _____@_____.com

Primary Care Physician: _____ Physician Phone: _____

Emergency Contact: _____ Contact Phone: _____

ATTORNEY & INSURANCE INFORMATION

Attorney's Name: _____ Attorney's Phone: _____

Attorney's Address: _____

Auto/Work Comp Insurance Name: _____ Insurance Phone: _____

Health Insurance Name: _____ Policy Number: _____

*Please present your insurance card at the front desk

EMPLOYMENT INFORMATION

Are you employed? Yes No (if yes) Name of Employer: _____ Occupation: _____

Employer Phone: _____ Employer Address: _____

Have you missed time from work because of this accident? Yes No Last Date Worked: _____

How many hours do you work in an average work week: _____

Please indicate your daily job duties and any activities you are occasionally asked to perform: _____

ACCIDENT/INJURY INFORMATION

Date of accident ___/___/___ Time: _____^{AM}/_{PM} What state do you work in? RI MA Other: _____

State accident/injury took place in: RI MA Other: _____

If this was a Motor Vehicle Accident please complete this section:

Were you the: Driver Front Passenger Rear Passenger Pedestrian

Were you wearing a seatbelt? Yes No If yes, What type: Lap Shoulder

Did the airbags deploy? Yes No If yes, are there injuries resulting? _____

At the time of impact was your car: Stopped Moving If moving, at what speed: _____

Did your car impact another vehicle or structure? Yes No

Was the impact from the: Front Rear Left Right Other: _____

On impact were you looking: Straight ahead To the left To the right Looking up Looking down

If this was NOT related to a Motor Vehicle Accident please complete this section:

Was anyone else present during your accident? Yes No (if yes) Who? _____

Did you report your accident to your employer? Yes No (if yes) When? _____

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ACCIDENT/INJURY INFORMATION Continued

Please describe how the accident happened in your own words: _____

Did you go to the hospital or see a doctor? Yes No (If yes) Name of hospital or doctor: _____

How did you get to the hospital or doctors? Ambulance Private transportation When? _____

Were X-rays taken? Yes No Was medication given? Yes No

POLICE INFORMATION IF ACCIDENT

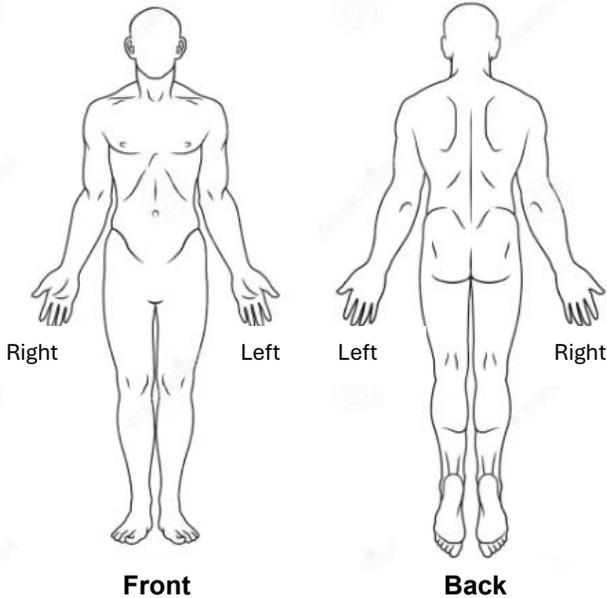
Did the police come to the scene of the accident?: Yes No (if yes, please answer questions below)

Was a police report filed? Yes No If yes, in what City/State was it filed? _____

If you have a report number, please provide it here: _____

INJURIES/SYMPTOMS

Please mark the area(s) of injury or discomfort on the images below. Indicate the degree of pain on all marked areas using a scale of 1 (least pain) for 10 (severe pain).



Have you had any of the following symptoms since your injury? Check all that apply

- | | |
|---|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Arm/Shoulder Pain | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Feet/Toe Numbness | <input type="checkbox"/> Sleep Difficulty |
| <input type="checkbox"/> Hand/Finger Numbness | <input type="checkbox"/> Upset Stomach |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Vision Blurred |

Type of Pain – Check all that apply:

- | | |
|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cramps | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Other: _____ |

Is this condition getting progressively worse? Yes No Is it constant? Yes No

Does it interfere with your: Work Sleep Daily Routine Recreation Other _____

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying Down
 Reaching Lifting Pushing/Pulling Prolonged Postures

MEDICAL HISTORY

Have you ever been in an accident before? Yes No (if yes, explain) _____

Do you take medication? Yes No (if yes, list:) _____

Do you have any health problems? Yes No (if yes, explain:) _____

Have you ever had surgery? Yes No (if yes, explain:) _____

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To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change and health.

Signature of Patient, Parent, or Guardian

Date

Please print name of Patient, Parent or Guardian

Relationship to Patient