Milwaukie Spine and Sport, LLC
2100 SE Lake Rd. Suite 1
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Workers Compensation Addendum

Tell us about your accident

Please notify us if you were **in a vehicle** at the time of the accident, you will need additional paperwork.

Date of Accident:___________Time of Accident:___________Location of Accident:_____________________________

Who is your employer?:_________________________________Contact info:__________________________________

Did you report the accident to your employer?(circle one): Yes No

Who is your employers compensation carrier?___________________Claim #:_________________________________

What type of work were you doing at the time of the accident?:____

Describe the accident:____

____

____

____

____

Did you receive treatment immediately following the accident? Yes No

(If yes, what type of treatment and where?)____

Did you receive a referral for chiropractic care? Yes No

(If yes, please provide us with a copy of your referral)

Tell us about your job

What is your job title:____________________________Is your job physically demanding?: Yes No

A typical 8-hour work day for me consists of(circle approximate):

Sitting	1	2	3	4	5	6	7	8	# of HRs
Standing	1	2	3	4	5	6	7	8	# of HRs
Walking	1	2	3	4	5	6	7	8	# of HRs

I perform the following activities while on the job(check all that apply):

❏ Bending	❏ Squatting	❏ Lifting	❏ Balancing	❏ Kneeling
❏ Crawling	❏ Climbing	❏ Typing	❏ Push/Pull	❏ Reaching
❏ Driving	❏ Lying Down	❏ __________	❏ __________	❏ __________

Patient Name:___________________DOB:_________ Provider:____________________Date:__________

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Symptoms after the Accident

(Please check all that apply)

On a scale of 1-10(10 being the worst) how bad is your pain currently?____

Were you able to move all parts of your body after the accident?

- ❏ Yes
- ❏ No, what couldn't you move?____

Are you currently off work as a result of the accident? Yes No

Did you lose consciousness as a result of the accident

Are you experiencing any of the following as a result of your accident?:

❏ Anxiety	❏ Irritability	❏ Depression	❏ Trouble sleeping
❏ Neck Pain/Stiffness	❏ Mid Back Pain/Stiff	❏ Low Back Pain/Stiff	❏ Light Sensitivity
❏ Pain Behind Eyes	❏ Headaches	❏ Dizziness	❏ Cold Sweats
❏ Flushing	❏ Tinnitus	❏ Loss of Balance	❏ Loss of smell
❏ Loss of Taste	❏ Loss of Memory	❏ Pins and Needles	❏ Short of Breath
❏ Heavy head	❏ Numb Extremities	❏ Cold Extremities	❏ Chest Pain
❏ Bowl changes	❏ Tension	❏ Fever	❏ Fainting
❏ Seizures	❏ Hallucinations	❏ Vision changes	❏ Confusion

Patient Name:________________________DOB:__________ Provider:________________________Date:___________