31 Navaho Ave., Mankato, MN 56001
507-345-4035

1 ABOUT YOU

Today's Date: ____________________________

Name: ________________________________

2a WORK RELATED ACCIDENT

Date of Accident: _________________________

Time of Accident: _________________________

Was your accident directly related to your work? ___ Y ___ N

Briefly describe the events that occurred just before and during your accident: ______________________

____

____

____

Give the address where accident occurred (if other than employer's address): ____________________

____

Was anyone else present during your accident? ___ Y ___ N

Did you report your accident to your employer? ___ Y ___ N

What recommendations did your employer make just after your accident? ___________________________

____

Has this type of accident happened to you before? ___ Y ___ N

If yes, when? ________________________________

To the best of your knowledge, has this accident occurred in your workplace before? ___ Y ___ N

In general:

Is your job physically stressful? ___ Y ___ N

Is your job mentally stressful? ___ Y ___ N

Is your workplace noisy? ___ Y ___ N

Have you changed jobs in the last year? ___ Y ___ N

3 AFTER INJURY

Did accident render you unconscious? ___ Y ___ N

If yes, for how long? ___________________________

Please describe how you felt immediately after the accident: ____________________________________

____

____

Have you gone to a Hospital or seen any other Doctor for this condition? ___ Y ___ N

When did you go? ___ Just after accident ___ The next day ___ 2 days plus

How did you get there? ___ Ambulance or ___ Private transportation

Name of Hospital and/or Attending doctor: __________

____

Was he/she a ___ D.C. ___ M.D. ___ D.O. ___ D.D.S.

Describe any treatment you received: ______________

____

Were x-rays taken? ___ Y ___ N

Please list any medications you were prescribed:

____

Have you been able to work since this injury? ___ Y ___ N

Are your work activities restricted as a result of this injury? ___ Y ___ N ___ Unable to work

Please indicate the symptoms that are a result of this accident:

___ Dizziness
___ Difficulty sleeping
___ Jaw problems
___ Nausea
___ Memory loss
___ Irritability
___ Arms/Shoulder pain
___ Back pain
___ Headache(s)
___ Fatigue
___ Numb Hands/Fingers
___ Lower back pain
___ Blurred vision
___ Tension
___ Chest Pain
___ Back stiffness
___ Buzzing in ear
___ Neck pain
___ Shortness of breath
___ Leg pain
___ Ears ringing
___ Neck stiff
___ Stomach upset
___ Numb Feet/Toes
___ Other ___________________________________

Is your condition getting worse? ___Y ___ N

___ Constant ___ Comes & goes

Indicate your degree of comfort while performing the following activities:

1=Comfortable 2=Uncomfortable 3=Painful (even if only sometimes)

___ Lying on back ___ Lying on side
___ Lying on stomach ___ Sitting
___ Standing ___ Stretching
___ Lovemaking ___ Walking
___ Running ___ Sports
___ Working ___ Lifting
___ Bending ___ Kneeling
___ Pulling ___ Reaching

Have you retained an attorney ___ Y ___ N
If yes, whom: ______________________________
His/Her Phone #: ___________________________

4 **RECOVERY**

To evaluate the effect that continuing work will have on your recovery, please complete the following:
How many hours are in your normal work day? _____
Please indicate your daily job duties and any activities which you are occasionally asked to perform:

___ Standing ___ Driving ___ Sitting
___ Operating equipment ___ Twisting
___ Walking ___ Work with arms above head
___ Crawling ___ Typing ___ Lifting
___ Bending ___ Stooping
___ Other ___________________________________

What positions can you work in with minimum physical effort and for how long? _______________
____ N/A

Prior to the injury were you capable of working on an equal basis with others your age? ___Y ___ N ___ N/A

Do you work with others who can help you with any heavy lifting? ___ Y ___ N ___ N/A

While in recovery, is there any light-duty work you could request? ___ Y ___ N ___ N/A

5a **WORKERS COMPENSATION INSURANCE**

Employer: ______________________________
Employer's Phone #: _______________________
Contact Person: ___________________________

Please provide copies of all information given to you by your employer to the receptionist.

______________________ Patient Signature ______________ Date