

Work-Related Accident Form

Name _____

Date _____

Time and date of accident: Date _____, Time _____ () AM () PM

First day lost from work (if applicable) _____ Went back to work _____ () normal duty,
() light duty until: _____

Was an injury report filed with your employer: () No () Yes- () same day () other: _____

When did you first notice the symptoms: () immediately () within hours () that night () the next day
() other _____

How accident / injury happened: _____

Did you go to the emergency room? () No () Yes: Where _____

Did they perform any tests (X-Rays, MRI, CAT Scans)? () No () Yes: which: _____

Are you or were you under any other health professional's care for this injury? () No () Yes: describe: _____

Have you ever had a similar condition in the past? () No () Yes: describe: _____

Please describe your job: _____

Hours per day that you work: (circle one): 1 2 3 4 5 6 7 8 9 10 11 12 _____

Total hours that your work each week: _____ () exact number () average

Please circle how many hours your are in the below postures each day:

Sitting: 0 1 2 3 4 5 6 7 8 9 10 11 12 _____
Standing: 0 1 2 3 4 5 6 7 8 9 10 11 12 _____
Walking: 0 1 2 3 4 5 6 7 8 9 10 11 12 _____
Driving: 0 1 2 3 4 5 6 7 8 9 10 11 12 _____

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Please mark the two descriptions below that apply to your work activities:

- Sedentary: lift 10 lbs max
- Light: lift up to 20 lbs max
- Medium up to 50 lbs max
- Heavy: lift up to 100 lbs max
- Very Heavy over 100 lbs occasionally
- Other, please describe: _____
- Occasionally carry small objects
- Frequently lift/carry up to 10 lbs
- Frequently lift/carry up to 25 lbs
- Frequently lift/carry up to 50 lbs
- Frequently lift/carry over 50 lbs

Please circle the percentage below that you perform each activity in a single day:

- Bending: 0% 25% 50% 75% 100%
- Turn/Twist: 0% 25% 50% 75% 100%
- Kneeling: 0% 25% 50% 75% 100%
- Squatting: 0% 25% 50% 75% 100%
- Crawling: 0% 25% 50% 75% 100%
- Climbing: 0% 25% 50% 75% 100%

- Repeated arm motions: 0% 25% 50% 75% 100%
- Reaching up above shoulder: 0% 25% 50% 75% 100%
- Foot controls: 0% 25% 50% 75% 100%
- Using a computer mouse: 0% 25% 50% 75% 100%

Is a lawyer helping you with this case?

- No Yes: Name and Phone # _____

Insurance companies involved:

Insurance company _____
Address _____

Claim # _____ Phone _____
Adjustor's Name _____

Have you retained an attorney? Yes No
If yes, who? _____ Phone _____

Assignment Of Benefits

By signing this form you authorize your insurance company to make payments directly to Rosenthal Chiropractic, P.A.

Signature of patient or legal guardian **Date**

Office Use only: Reviewed by: _____ Date _____