Burlington Family Chiropractic

Injury Report

Name: _____ Social Sec. #: _____ Home Phone: _____

Address: _____ City: _____ St. ___ Zip _____

Sex: M F Birth date: _____ Marital Status: M S D W Occupation: _____

Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ St. ___ Zip _____

*Please explain in detail how your accident happened _____

_____

_____

_____

_____

Have you retained an attorney? _____ Yes _____ No

Attorney's name and address _____

_____

*What was the date & time of this injury? _____ AM or PM, and Date _____/_____/____ State it happened? ____

*Where did this injury occur? _____ at work _____ at home _____ in car _____ other (explain) _____

Did you feel pain immediately following the accident? _____ Yes _____ No

Did you go the emergency room? _____Yes _____No Name of Hospital? _____

Doctor Name? _____ _____ M.D. _____D.C. _____ D.O. _____D.D.S.

Diagnosis _____ Treatment _____

Frequency of visits _____ Duration of treatment _____

What have you done to relieve your symptoms? _____

Have you ever injured this area before? _____ Yes _____ No When? _____

Before this injury were you able to work on an equal basis as others your age? _____ Yes _____ No

Since this injury are your symptoms _____improving? _____ Getting worse? _____The same?

**********WORKER'S COMPENSATION ACCIDENT INFORMATION ONLY**********

Name of W/C contact at work _____ Title: _____

Did you report this injury to your employer? ____ Yes _____ No

Did you return to work? _____ Yes _____ No If so, dates missed _____ through _____

Have you had Work Comp injuries before? ____ Yes _____ No If so, how many times? _____

Name of other doctors you have consulted for previous W/C injuries _____

Do previous injuries affect your employment? _____ Yes _____ No

Do you favor any part of your body when you work? _____ Yes, Explain _____ _____ No

Turn to other side and continue

**********AUTOMOBILE ACCIDENT INFORMATION ONLY**********

Driver of vehicle in which you were injured: _____ Insured: _____

Auto Ins. Co: _____ Address: _____

Phone # _____ Policy # _____ Claim # _____

Driver of other vehicle (if applicable) Name: _____ Insured: _____

Auto Ins. Co: _____ Address: _____

Phone # _____ Policy # _____ Claim # _____

You were heading ____ North _____ South _____ East _____ West on _____(street/highway)

Other vehicle headed _____North _____ South _____ East _____ West on _____(street/highway)

You were struck from _____ behind _____ front _____ right side _____ left side

You were the _____ driver _____ passenger _____ middle _____ front seat _____ back seat

_____ using belts _____ air bags

Were you knocked unconscious? _____ Yes ____ No How long? _____

Police notified? ____Yes _____ No Do you have a police report? _____ Yes ____ No

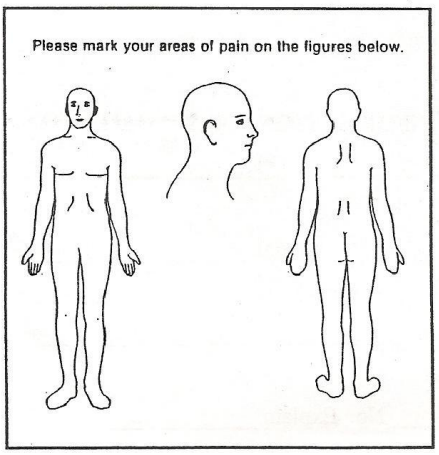
Where treatment was given? _____

PLEASE INDICATE ALL OF THE SYMPTOMS BELOW YOU ARE PRESENTLY EXPERIENCING

MUSCULO-SKELATAL SYSTEM
____ Low back problems
____ Pain between shoulders
____ Neck problems
____ Arm problems
____ Leg problems
____ Swollen joints
____ Painful joints
____ Stiff joints
____ Sore muscles
____ Weak muscles
____ Walking problems
____ Ruptures
____ Broken bones

GENITO-URINARY SYSTEM
____ Bladder trouble
____ Excessive urination
____Scanty urination
____ Painful urination
____ Discolored urine

FEMALE
____ Vaginal discharge
____ Vaginal bleeding
____ Vaginal pain
____ Breast pain
____ Lumps on breast
Are you pregnant?
___Yes ___ No



GASTRO-INTESTINAL SYSTEM
____ Poor appetite
____ Excessive hunger
____ Difficult chewing
____ Difficult swallowing
____ Excessive thirst
____ Nausea
____ Vomiting food
____ Vomiting blood
____ Abdominal pain
____ Diarrhea
____ Constipation
____ Black stool
____ Bloody stool
____ Hemorrhoids
____ Liver trouble
____ Gall bladder problems
____ Weight trouble

NERVOUS SYSTEM
____ Numbness
____ Loss of feeling
____ Paralysis
____ Dizziness
____ Fainting
____ Headaches
____ Muscle jerking
____ Convulsions
____ Forgetfulness
____ Confusion
____ Depression

CARDIO-VASCULAR RESPIRATORY
____ Chest pain
____ Pain over heart
____ Difficult breathing
____ Persistent cough
____ Coughing phlegm
____ Coughing blood
____ Rapid heartbeat
____ Blood pressure problems
____ Heart problems
____ Lung problems
____ Varicose Veins

EYE, EAR, NOSE AND THROAT
____ Eye strain
____ Eye inflammation
____ Vision problems
____ Ear pain
____ Ear noises
____ Ear discharge
____ Hearing loss
____ Nose pain
____ Nose bleeding
____ Nose discharge
____ Diff breathing thru nose
____ Sore gums
____ Dental problems
____ Sore mouth
____ Sore throat
____ Hoarseness
____ Difficult speech

_____ _____
Patient Signature Date