Aspen Chiropractic Clinic, LLC
7417 SW Beaverton Hillsdale Hwy | Ste 200
Portland OR 97225
503.291.7155

Patient Registration for Work Related Injury

The information you provide is confidential and will not be reproduced or shared without your permission unless permitted by law.

First name ______________________ **MI** ____ **Last name** ______________________________

Gender ____________ **Birth date** ______________________ **Social security #** ____________________

Drivers license # ____ **Issued in which state?** ____________

Home address ______________________________ **City** ______________ **State** ________ **Zip** _________

Home phone # ______________________________ **Voice mail/Pager #** ____________________________

Name of employer at time of injury __________________________________ **Their Phone #** ____________

Their address ______________________________ **City** ______________ **State** ________ **Zip** _________

Occupation at time of injury ___________________________ **Length of employment** __________________

Your present occupation ______________________________ **Length of employment** __________________

Your present employer ____________________________________ **Work phone #** ________________

[circle one] **Spouse, Partner or Parent name** ________________________ ***Their phone #*** ________________

Emergency contact person ______________________________ ***Their phone #*** ________________

Who referred you or how did you hear about this office? ______________________________________

Who is filling out this questionnaire? __________________________ ***Relationship to patient:*** ____________

Day and date of the accident ___________________________ **Time of the accident** ______________ **AM / PM**

Location of accident ________________________________ **Witness name** ______________________

Name of person the accident was reported to: ____

Did you file Form 801 with your employer after the accident? [circle one] **No Yes** ***Please give us a copy of the report for your file.***

Describe the accident in your own words: ____

____

____

Describe how you felt immediately after the accident: _________________________________

____

____

On the following pain scale diagram, circle the number from 0 to 10 that best represents the level of pain you felt immediately after the accident:

No pain = **0 1 2 3 4 5 6 7 8 9 10** *= Incapacitating pain*

List and describe the parts of your body that were injured or cause you pain or discomfort as a result of this accident, *including all bumps, bruises, broken bones, cuts, scrapes, scratches, or marks on your body.*

____

____

____

____

Did you receive medical attention at the scene? [circle one] **No Yes**

Were you taken to a hospital? [circle one] **No Yes** ***Name of hospital*** ____________________________

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What did you do immediately after the accident or hospital? [circle one] Went home Went back to work Went to a doctor

Has another doctor treated you since the accident or hospital? [circle one] No Yes ***Still treating?*** [circle one] No Yes

Date of your FIRST treatment________________________________**Diagnosis**________________________________

Doctor's Name________________________________ [circle one] MD DO DC ND **Phone #**____________________

Address or location where you were treated ____

Have x-rays or MRI films been taken for your current condition? [circle one] No Yes ***When?***____________________

What other tests have been done to diagnose or monitor your current condition? ____________________________

____***When?***______________________________

Are you taking any prescription medications for your work injury? [circle one] No Yes

Please list the names of those prescription medications you are taking for your injury. Be sure to indicate the dosage or how much you take and how often you take it:

1.____ **2.**____

3.____ **4.**____

Please list all OTHER medicines you take for other health conditions even if you take herbs or vitamins.

Name	*Why do you take it?*	*What dosage?*	*Taken for how long?*

Describe your symptoms from the day after the accident until today:____

____

____

On the following pain scale diagram, circle the number from 0 to 10 that best represents the typical level of pain you have felt from the day after the accident until today.

No pain = **0 1 2 3 4 5 6 7 8 9 10** *= Incapacitating pain*

Are your work activities restricted as a result of this accident? [circle one] No Yes

If Yes, please describe or give me a copy of your work restriction: ____

____

What is the LAST date that you worked full or part time after the accident? ________________________________

Before the accident were you capable of working on an equal basis with others your age? [circle one] No Yes

Were you involved in any prior work accidents? [circle one] No Yes ***In what month and year?***____________________

Were you involved in any prior auto accidents? [circle one] No Yes ***In what month and year?***____________________

Did you have any physical complaints caused by a prior accident that were bothering you before this accident or that are worse after this accident? [circle one] No Yes

Please describe:____

Did you have any other physical complaints or problems before this accident? [circle one] No Yes

Please describe:____

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Your Current Job Description

In terms of an 8- hour workday, "occasionally" means 33%, "frequently" means 34%- 66%, and "continuously" means 67%- 100% of the day.

1. ***In a typical 8- hour workday, I:*** **[please circle the number of hours of activity]**

Sit	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8 hours**
Stand	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8 hours**
Walk	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8 hours**

2. ***On the job, I perform the following activities:*** **[circle one for each activity]**

Bend, Stoop	**Not At All**	**Occasionally**	**Frequently**	**Continuously**
Squat	**Not At All**	**Occasionally**	**Frequently**	**Continuously**
Crawl	**Not At All**	**Occasionally**	**Frequently**	**Continuously**
Climb	**Not At All**	**Occasionally**	**Frequently**	**Continuously**
Reach over shoulder level	**Not At All**	**Occasionally**	**Frequently**	**Continuously**
Crouch	**Not At All**	**Occasionally**	**Frequently**	**Continuously**
Kneel	**Not At All**	**Occasionally**	**Frequently**	**Continuously**
Balancing	**Not At All**	**Occasionally**	**Frequently**	**Continuously**
Push, pull	**Not At All**	**Occasionally**	**Frequently**	**Continuously**

3. ***On the job, I lift:*** **[circle all that apply]**

Up to 10 pounds	**Not At All**	**Occasionally**	**Frequently**	**Continuously**
11 to 24 pounds	**Not At All**	**Occasionally**	**Frequently**	**Continuously**
25 to 34 pounds	**Not At All**	**Occasionally**	**Frequently**	**Continuously**
35 to 50 pounds	**Not At All**	**Occasionally**	**Frequently**	**Continuously**
51 to 74 pounds	**Not At All**	**Occasionally**	**Frequently**	**Continuously**
75 to 100 pounds	**Not At All**	**Occasionally**	**Frequently**	**Continuously**

4. **Do you have to bend over while doing any lifting?** **[circle one] No Yes**

5. **Are your feet used for repetitive movements, such as in operating foot controls?** **[circle one] No Yes**

6. **Do you use your hands for repetitive actions, such as:** **[circle all that apply]**

***Right hand*:**	**Simple Grasping**	**Firm Grasping**	**Fine Manipulating**
***Left hand*:**	**Simple Grasping**	**Firm Grasping**	**Fine Manipulating**

7. **Are you required to work on unprotected heights?** **[circle one] No Yes**

8. **Are you required to be around moving machinery?** **[circle one] No Yes**

9. **Are you exposed to marked changes in temperature and humidity?** **[circle one] No Yes**

10. **Are you required to drive automotive equipment?** **[circle one] No Yes**

11. **Are you exposed to dust, fumes and/ or gases?** **[circle one] No Yes**

Signature ______________________________ **Date**______________________

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Health History

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Personal History

Name ______________________________ **Date of Birth** ______________ **Age** ________

[circle one] **Right handed** **Left handed** **Ambidextrous** **Your HEIGHT:** ________ *feet* __________ *inches*

Your *current* WEIGHT: ________ *pounds* **Your *normal* WEIGHT:** ________ *pounds*

Have you recently gained or lost a significant amount of weight? [circle one] **Yes No** *If YES, how much and over what time period?*______________________________

***Female patients*, please answer the following questions:**

Are you pregnant, or do you have any reason to believe that you could be pregnant? [circle one] **Yes No**

Number of children __________ **Number of pregnancies** __________ **Number of births** __________

Social History *Please check the appropriate column if any of the following apply to you:*

PAST	PRESENT			
☐	☐	Tobacco	Per day ______	or per week__________
☐	☐	Alcohol	Per day ______	or per week__________
☐	☐	Caffeinated drinks	per day ______	or per week__________
☐	☐	Decaffeinated coffee	per day ______	or per week__________
☐	☐	Drugs and related substances		

Past Health History

PRIOR INJURIES

Please list all major past injuries, even if you never received medical care

INJURY	DATE OCCURRED	WORK RELATED [yes or no]	DOES THE CONDITION RECUR [yes or no]

PRIOR ADULT ILLNESSES

Please list all serious illnesses, such as *ASTHMA, CANCER, DIABETES, HEART DISEASE, HEPATITIS, HIGH BLOOD PRESSURE, HIV INFECTION, SEIZURES, SICKLE CELL ANEMIA, TUBERCULOSIS.*

DATE	DIAGNOSIS	TREATMENT GIVEN	ANY REMAINING PROBLEMS?

PRIOR SURGERIES & HOSPITALIZATIONS

Please list all major surgeries/ operations and times you were hospitalized, even if you never had surgery

DATE	TYPE OF SURGERY OR CAUSE OF HOSPITALIZATION	ANY COMPLICATIONS?	ANY REMAINING PROBLEMS?

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Family History ***Please tell us about your birth parents and blood relatives if this information is available to you***

Mother is [circle one] **LIVING DECEASED Age________Cause of death____________________________**

Father is [circle one] **LIVING DECEASED Age________Cause of death____________________________**

Please check the appropriate column if any of the following apply now or in the past to your blood relatives

☐	**Alcoholism**	☐	**Cancer**
☐	**Allergies**	☐	**Diabetes mellitus**
☐	**Arthritis**	☐	**Heart Disease**
☐	**Anemia, blood, bleeding disorders**	☐	**Inherited disorder ________________________________**

Your Symptoms List ***Please check the appropriate column for symptoms you have experienced before (PAST) or for symptoms you currently experience (PRESENT)***

PAST	PRESENT		PAST	PRESENT	
☐	☐	**General fatigue**	☐	☐	**Skin rash, dermatitis, eczema**
☐	☐	**Headache**	☐	☐	**Chronic sinus problems**
☐	☐	**Tinnitus, noises in the ear**	☐	☐	**Excessive thirst**
☐	☐	**Fainting**	☐	☐	**Chronic cough**
☐	☐	**Vision disturbances**	☐	☐	**Chest pain**
☐	☐	**Convulsions**	☐	☐	**Rapid heart beat**
☐	☐	**Dizziness, lightheadedness**	☐	☐	**Difficulty swallowing**
☐	☐	**Muscular incoordination**	☐	☐	**Heartburn and/ or indigestion**
☐	☐	**Generalized muscle pain**	☐	☐	**Loss of appetite**
☐	☐	**TMJ (jaw) pain**	☐	☐	**Nausea**
☐	☐	**Neck pain**	☐	☐	**Abdominal pain**
☐	☐	**Back pain**	☐	☐	**Loss of bladder or bowel control**
☐	☐	**Joint swelling**	☐	☐	**Painful urination**
☐	☐	**Joint stiffness**	☐	☐	**Frequent urination**
☐	☐	**Shoulder pain**	☐	☐	**Difficult urination or changes in stream**
☐	☐	**Arm pain**	☐	☐	**Constipation**
☐	☐	**Elbow pain**	☐	☐	**Irregular bowel habits**
☐	☐	**Wrist, Hand pain**	☐	☐	**Irregular menstrual flow**
☐	☐	**Hip pain**	☐	☐	**Excessive menstrual flow**
☐	☐	**Leg pain**	☐	☐	**Breast tenderness and/ or lumps**
☐	☐	**Knee pain**	☐	☐	**Vaginal discharge**
☐	☐	**Ankle, foot pain**	☐	☐	**PMS**
☐	☐	**Enlarged lymph nodes, glands**	☐	☐	**ED**

Signature ____ Date______________________

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