Trimboli Chiropractic
648 Park Avenue
Huntington, New York 11743
(631) 421-4300

Please Note: You MUST provide the date of the accident, and the name, address, and phone number of the Workers' Compensation insurance carrier and a copy of the accident report you filed with your employer <u>before</u> being evaluated.

Today's Date________________________

Name: _________________________________ Date of Accident: ___________________

1. Name of employer at the time of accident: __________________________________
2. Type of work being done at time injury: ___________________________________
   ____
3. In your own words, please describe accident: ______________________________
   ____
   ____
   ____
4. Have you been treated by another medical doctor or chiropractor for this accident?
   _____Yes _____No
   If yes, please list doctor's name and phone number: __________________________
   ____
   What type of treatment did you receive? ___________________________________
   How long were you treated by this doctor? _________________________________
5. Are you: ( ) improved ( ) unchanged ( ) getting worse
6. What types of medicines are you taking? __________________________________
   ____
7. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?
   ( ) Yes ( ) No ( ) Don't know
   If yes, describe: ____
   ____
   ____
8. Were these similar complaints the results of previous accident(s)?
   ( ) Yes ( ) No ( ) Not Applicable
   Please provide details of accident(s): _____________________________________
   ____
   ____

9.. Have you had any other serious accidents which required medical care?
   ( ) Yes ( ) No
   Describe: ____

10. Have you had any serious illnesses that required hospitalization?
   ( ) Yes ( ) No
   Describe: ____

11. Have you had any surgeries? ( ) Yes ( ) No

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If yes, list type of surgery and dates: ____
____
____

12. Have you had any nervous or mental illnesses? ( ) Yes ( ) No
13. Have you returned to work since this accident? ( ) Yes ( ) No
    If you have returned to work since your accident, please fill out the information below:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY REG. DUTY	FULL-TIME PART-TIME

Current Medical Complaints

Back Pain:

1. Currently, I have pain in my:........................... ( ) low back ( ) mid back ( ) upper back
2. My pain began: .... ( ) gradually ( ) suddenly
3. I have pain:.. ( ) sometimes ( ) all of the time
4. My pain goes into my: .... ( ) right leg ( ) left leg ( ) both ( ) neither
5. I have tingling and/or numbness in my: .... ( ) right leg ( ) left leg ( ) both ( ) neither
6. My pain is worse when I:
   - cough or sneeze.................................... ( ) Yes ( ) No
   - sit .... ( ) Yes ( ) No
   - bend .... ( ) Yes ( ) No
   - walk.. ( ) Yes ( ) No
   - lift .... ( ) Yes ( ) No
   - push.. ( ) Yes ( ) No
   - pull .... ( ) Yes ( ) No
7. My back pain is worse with sexual activity .... ( ) Yes ( ) No
8. My pain wakes me up during the night........... ( ) Yes ( ) No
9. Changes in the weather affect my pain............ ( ) Yes ( ) No

Neck Pain: Complete only if applicable

1. My neck pain began: ( ) gradually....... ( ) suddenly
2. I have pain: ( ) sometimes..... ( ) all of the time
3. My pain goes into my: ( ) right arm....... ( ) left arm ( ) both
4. I have tingling and/or numbness in my: ( ) right arm....... ( ) left arm ( ) both

Neck Pain (continued):

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5. My pain is worse when I:

cough or sneeze	( ) Yes	( ) No
bend forward	( ) Yes	( ) No
lift	( ) Yes	( ) No
push	( ) Yes	( ) No
pull	( ) Yes	( ) No
turn my head	( ) Yes	( ) No
6. My pain wakes me up during the night	( ) Yes	( ) No
7. Changes in the weather affect my pain	( ) Yes	( ) No
8. I have neck stiffness	( ) Yes	( ) No
9. I have headaches	( ) Yes	( ) No
10. If I do get headaches, they occur:	( ) sometimes	( ) all of the time

Other Pain:
Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition. ____
____
____

Job Description:
(In terms of an 8 hour workday, "occasionally" means 33%, "frequently" means 34% to 66% and "continuously" means 67% to 100% of the day.)

1. In a typical 8-hour workday, I: (Circle # of hours / 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:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend/stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Reach above shoulder level	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Balancing	( )	( )	( )	( )
Pushing/ Pulling	( )	( )	( )	( )

3. On the job, I lift:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Up to 10 pounds	( )	( )	( )	( )

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11 to 24 pounds	( )	( )	( )	( )
25 to 34 pounds	( )	( )	( )	( )
35 to 50 pounds	( )	( )	( )	( )
51 to 74 pounds	( )	( )	( )	( )
75 to 100 pounds	( )	( )	( )	( )

4. Do you have to bend over while doing any lifting? ( ) Yes ( ) No
5. Are your feet used for repetitive movements, such as in operating foot controls? ( ) Yes ( ) No
6. Do you use your hands for repetitive actions, such as:

	SIMPLE GRASPING	FIRM GRASPING	FINE MANIPULATION
Right Hand	( ) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No
Left Hand	( ) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No

7. Are you required to work on unprotected heights? ( ) Yes ( ) No
   Describe: ____
   ____
   ____
8. Are you required to be around moving machinery? ( ) Yes ( ) No
   Describe: ____
   ____
   ____
9. Are you exposed to marked change in temperature and humidity? ( ) Yes ( ) No
   Describe: ____
   ____
   ____
10. Are you required to drive automotive equipment? ( ) Yes ( ) No
    Describe: ____
    ____
    ____
11. Are you exposed to dust, fumes and/or gasses? ( ) Yes ( ) No
    Describe: ____
    ____
    ____
12. Please list any additional comments: ______________________________________
    ____
    ____
    ____

Signature ______________________________________ Date __________________