New Patient Intake - Labor and Industries

Owens Chiropractic P.S. 33650 6th Ave S. Suite 100 Federal Way, WA 98003 (P) 253-942-3300

Patient Name: ____

Date of Injury:____

Location of Injury: ____

Time of Injury: ____

Employer: ____

Employer's Address: ____

Job Title:____

Assigned job duties:____

____

In as much detail as possible please describe how the injury occurred:

____

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____

Could you move all parts after the injury? Yes ___ No ____

If no, what parts of your body could you not move? ______________________________________

Were you able to walk unaided following the accident? Yes _____ No ______

Did you sustain any bruises, bleeding of lacerations? _____________________________________

Did you have to be transported to a hospital or emergency care facility for further evaluation?

____

Doctor and/ or Facility Name:____

Facility Address:____

Were x-rays taken? What body parts?____

What treatment did they provide? Did you receive benefit?

____

____

Check the symptoms that appeared or been exacerbated since the injury:

__Ankle Pain Lt or Rt
__Knee Pain Lt or Rt
__Hip Pain Lt or Rt
__Leg Pain - Lt or Rt
__Low Back Pain
__Mid Back Pain
__Neck Pain
__Headaches
__Shoulder Pain – Lt or Rt
__Elbow Pain Lt or Rt
__Hand Pain Lt or Rt
__Memory Difficulty
__Depression
__Anxiety
__Fatigue
__Irritability
__Rib Pain
__Clicking Jaw
__Cold/ Numbness in Extremities
__Tingling in Extremities
__Sleeping Problems
__Tinitus
__Dizziness/ Vertigo
__Light headed