Michael W. Bohrnsen DC, DACBSP
15312 E. Sprague Ave. #23
Spokane Valley, WA 99037
(509) 828-0538

Date:_____

WORK RELATED INJURY INFORMATION

Name_____Address_____
City_____State_____ Zip_____ Phone _____Work#_____
Claim # _____ SS#_____Injury Date_____DOB_____

Employer at the time of injury_____
Who referred you to this office? _____
How long had you been working for this employer at the time of your injury?_____
Occupation at the time of your injury _____
Describe accident in Detail_____
_____
_____
_____

Did you report the injury to anyone at work (circle one)? YES NO If yes, to whom _____
Did you continue working after your injury (circle one)? YES NO If no, when did you return to work_____
Are you currently working (circle one): Without Restrictions With Light Duty Restrictions UNABLE to Work
If you have restrictions, what are they?_____
How many days of work have you missed due to your injury?_____
What areas were injured?_____
What symptoms did you feel immediately after the accident?
_____
Please List any symptoms that developed later
_____
_____
Have you had any of these symptoms before? YES NO Were you treated for them? YES NO
Please list all **doctors/therapists** you have seen for your injury. List Them in order you saw them
_____
_____
_____
_____

Which doctors/therapists are you currently seeing for your injuries?
_____
_____

Are you satisfied with the care you are receiving (Circle one)? YES NO

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Do you have any concerns about your injury?
_____

Have you ever received an impairment or disability rating? YES NO If Yes, When _____
Have you ever received a settlement for a previous work related injury or auto accident? YES NO
If yes, When? _____ What areas were injured? _____

CURRENT WORK STATUS

Presently Working? YES NO Employer _____

Occupation _____ Employer Phone _____ For How Long? _____

Present Complaints

Listed in order of Severity
1) _____
2) _____
3) _____
4) _____

Are They (circle one) Constant Come & Go Is the pain: Sharp Dull Other _____

Do your symptoms interfere with: **Work** YES NO **Sleep**: YES NO **Daily activities** YES NO
What activities, movements or positions make your pain worse?
_____
_____

What can you do to ease your pain? _____

How much overall improvement have you made since your injury? _____%
How long has it been since you had noticed significant improvement? _____

Using a scale of 0-10 (0 = no pain & 10 = worst pain you can imagine) Rate your PAIN:
On the Average _____ At its worst _____ Today _____
Pain Medications Taken Today:_____

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Use the following symbols, please mark on the drawing areas of pain or discomfort

XX - Sharp Pain :: - Dull Pain
// - Numbness 00-Tingling B - Burning

PAST MEDICAL HISTORY

Injuries: _____
_____
_____

Illnesses:_____
Operations:_____
Hospitalizations:_____
Medical Allergies:_____
Current Medications:_____

FAMILY HEALTH HISTORY

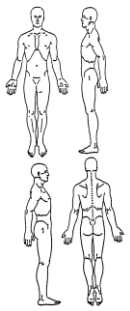
List any serious illness in your household (write N/A if not applicable) _____

Parents: Living List health problems (if deceased include age and cause of death)
Mother Yes/No _____

Father Yes/No_____

Any significant diseases in your immediate family (parents, brothers, sisters)? _____
_____

My immediate relatives have (circle any that apply)
High Blood Pressure Heart Disease Cancer Diabetes



SOCIOECONOMIC DATA

Current marital status (circle one):

Married Single Seperated

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Dependent children (please give their names and ages):

Boys_____

Girls_____

Education: HS Graduate? Yes No Attend College? Yes No List Degrees _____

Military History: Yes No

Branch of Service _____ Years of Service _____ Discharged Yes No

Type of Discharge _____ Any service Related disabilities? Yes No

Habits:

Sleep:

How many hours per day? _____

Do you fall asleep easily? Yes No

Do you wake up during the night? Yes No

How many times? _____

Do you return to sleep easily Yes No

Exercise:

How many times per week? _____ Type of Exercise? _____

Caffeine: Coffee, teas or colas per day? _____

Tobacco: # of packs per day? _____

# of tins per week?_____

Alcohol # of drinks per day?_____

# of drinks per week?_____

Do you use cocaine, marijuna or heroine? (Circle one) Yes No

Hobbies and Interests:_____

REVIEW OF SYSTEMS: (Physicians use only)

HEENT _____

PULM_____

CV_____

GI_____

GU_____

NEURO_____

EMO/PSYCH_____