WORK / COMP HISTORY

Los Angeles Spinal Decompression ™

Patient ______________________________ Phone (   ) __________

Address ______________________ City __________ State ______ Zip ______

Age ______ Birthdate ______________ Sex ______ S/S # ______________

Name of Compensation Carrier: ______________________ Phone (   ) __________

Address of Carrier: ______________________ City __________ State ______ Zip ______

Employer's Name: ______________________ Phone (   ) __________

Employer's Address: ______________________ City __________ State ______ Zip ______

1. Type of Business ______________________ Your Occupation ______________
2. Date Injured ______ Hour ______ AM / PM Last Date Worked ______ Are you off work? ( ) Yes ( ) No
3. Previous Workers' Compensation Injury? ( ) Yes ( ) No
4. Accident reported to employer? ( ) Yes ( ) No Name of person reported accident to ______________
5. Injured at: ______________________ City __________ State ______ Zip ______
6. Length of time worked there prior to accident: ______________________
7. Type of work being done at time of injury: ______________________

   ____

8. In your own words, please describe accident: ______________________

   ____

   ____

   ____

9. Have you been treated by another doctor for this accident? ( ) Yes ( ) No

   If yes, please list doctor's name and address: ______________________

   ____

   What type of treatment did you receive? ______________________

   How long were you treated by this doctor? ______________________

10. Are you: ( ) improved ( ) unchanged ( ) getting worse
11. What types of medicines are you taking? ______________________

    ____

    - Do these medicines help? ( ) Yes ( ) No ( ) Don't know
12. Have you had physical therapy? ( ) Yes ( ) No If yes, how often?

    ( ) Daily ( ) Every other day ( ) Several times a week ( ) Weekly ( ) Every other week

    ( ) Monthly ( ) Other ______________________

    Does the physical therapy help? ( ) Yes ( ) No ( ) Don't know
13. 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: ______________________

    ____

    ____

    Were these similar complaints the results of a previous accident(s)? ( ) Yes ( ) No

    Please provide details of accident(s): ______________________

    ____

    ____

3. On the job, I lift:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Up to 10 pounds	( )	( )	( )	( )
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 MANIPULATING
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 changes 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 gases? ( ) Yes ( ) No

Describe: ____________________

12. Please list any additional comments: ____________________

Signature: ____________________ Date: ____________