Northgate Chiropractic

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Work Accident History

Workers' compensation clinical history · Complete on screen or print clearly

Account # (office use) _____ Today's date _____

PATIENT INFORMATION

Legal last name _____ Legal first name _____ Middle _____

Preferred name _____ Pronouns (optional) _____ Date of birth _____

Gender identity (optional — respectful care only; never used to deny services)

☐ Woman ☐ Man ☐ Non-binary ☐ Prefer not to say

Self-describe _____ Title (Mx/Mr/Ms/Dr…) _____

Sex assigned at birth (optional — skip if not needed)

☐ Female ☐ Male ☐ Intersex ☐ Prefer not to say

Relationship / household (optional)

☐ Married ☐ Partnered / domestic partner ☐ Single

☐ Widowed ☐ Divorced ☐ Prefer not to say

Street address _____ City _____ State _____ ZIP _____

Mobile phone _____ Home phone _____ Email _____

SSN (optional — often needed for L&I / WC billing) _____ Occupation / job title _____

Emergency contact

Name _____ Relationship _____ Phone _____

EMPLOYER INFORMATION

Company name _____ Supervisor name _____ Work phone _____

Address _____ City _____ State _____ ZIP _____

Nature of business (e.g. construction, retail, manufacturing) _____

INSURANCE AND CLAIM INFORMATION

Provide claim numbers and cards to staff when available. This form supports clinical care and billing documentation; L&I or the insurer may require separate claim filings.

Workers' comp / L&I claim # _____ Claim administrator / carrier _____

Adjuster name / phone _____ Health insurance (if any) _____

ACCIDENT / INJURY HISTORY

1. Date of accident / injury _____ Time of day _____ Date last worked _____

1b Onset: ☐ Gradual ☐ Sudden ☐ Progressive

2 Address / location where you were injured

Street / site _____ City _____ County _____

4 Did you report this to your employer? ☐ Yes ☐ No

4b If yes, to whom?

5 Did you go to a hospital or another doctor's office after the accident? ☐ Yes ☐ No

5a If yes, where?

5b Were X-rays taken? ☐ Yes ☐ No

5c What type of treatment was administered?

5d Was a diagnosis made? ☐ Yes ☐ No

5e If so, what was it?

6 Describe how the accident / injury happened

7 What is your number one problem or the one area of greatest pain?

8 Have you ever experienced this problem before? ☐ Yes ☐ No

8b When?

9 Rate this pain (0 = none, 10 = worst). Check one, or two for a range:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

10. How often do you experience the pain?

☐ 1–2 hours per day
☐ About half the day
☐ Most of the day
☐ The pain never goes away

WORK FUNCTION AND OTHER COMPLAINTS

11. How does the pain affect your daily activities?

☐ Does not affect work or home activities
☐ Changed how I do work or home activities
☐ Cannot do some activities (explain below)
☐ Unable to do nearly everything I am used to

11b Explain activity limits

12 What increases your pain?

13 What decreases your pain?

14. Other current complaints — describe each, then check a 0–10 rating:

a. ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

b. ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

c. ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

d. ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

15 Do you feel you could perform your usual job right now? ☐ Yes ☐ No

16 Describe your routine job duties

17 If you are working, how has your current condition affected normal duties?

18 Is there any activity or duty you are unable to perform?

19. How often does your job require you to do the following?

☐ Lifting (lbs)
☐ Sitting (hrs/day)
☐ Standing (hrs/day)
☐ Computer (hrs/day)

☐ Telephone (hrs/day) ____

☐ Driving (hrs/day) ____

Frequency (check one per activity if it applies):

☐ Push / pull	☐ Once in a while	☐ Often	☐ Frequently	☐ Almost all the time
☐ Reach overhead	☐ Once in a while	☐ Often	☐ Frequently	☐ Almost all the time
☐ Grasping	☐ Once in a while	☐ Often	☐ Frequently	☐ Almost all the time
☐ Twisting / bending	☐ Once in a while	☐ Often	☐ Frequently	☐ Almost all the time
☐ Squatting / kneeling	☐ Once in a while	☐ Often	☐ Frequently	☐ Almost all the time
☐ Walking	☐ Once in a while	☐ Often	☐ Frequently	☐ Almost all the time
☐ Climbing / ladders	☐ Once in a while	☐ Often	☐ Frequently	☐ Almost all the time

19z Other job demands (explain)

20 Injured at work prior to this accident / injury? ☐ Yes ☐ No

20a When?

20b Explain

21 Involved in an automobile accident before? ☐ Yes ☐ No

21a When?

21b Were you injured? ☐ Yes ☐ No

21c Explain

22 List all surgeries (with approximate dates)

23 List all medications you currently take (prescribed and OTC)

24 Anything else you would like the doctor to know?

HEALTH HISTORY CHECKLIST

Mark P = past condition, C = currently experiencing. Answer only as comfortable.

P	C	Condition
☐	☐	Heart attack / heart disease
☐	☐	Arthritis
☐	☐	Diabetes
☐	☐	Fainting spells
☐	☐	Difficulty with urination
☐	☐	Difficulty with bowel movements
☐	☐	Cancer
☐	☐	HIV
☐	☐	Diverticulosis
☐	☐	Dizziness
☐	☐	Chest pain
☐	☐	Constipation
☐	☐	General fatigue
☐	☐	Nausea
☐	☐	Soreness in joints
☐	☐	Ears ringing (tinnitus)
☐	☐	Migraine
☐	☐	Gout

P	C	Condition
☐	☐	Stroke / TIA
☐	☐	Gallbladder trouble
☐	☐	Glaucoma
☐	☐	Kidney stones / disease
☐	☐	Bloody stools
☐	☐	Anemia
☐	☐	Asthma
☐	☐	Ulcers
☐	☐	Menstrual cramping / pelvic pain
☐	☐	Loss of memory
☐	☐	Shortness of breath
☐	☐	Diarrhea
☐	☐	Sudden weight loss
☐	☐	Muscle cramping
☐	☐	Loss of hearing
☐	☐	Headache
☐	☐	Epilepsy / seizures
☐	☐	Tuberculosis

- ☐ ☐ STI (note details if needed)
- ☐ ☐ Broken bones
- ☐ ☐ Sprained ankle — left
- ☐ ☐ Blood clots / DVT
- ☐ ☐ Knee / hip replacement
- ☐ ☐ Sprained ankle — right
- ☐ ☐ Osteoporosis / low bone density
- ☐ ☐ Pregnant or possible pregnancy

Notes / specify

GENERAL ACTIVITIES

Check all that apply to your usual routine.

- ☐ Sleep on waterbed
- ☐ Sleep on stomach
- ☐ Sewing
- ☐ Exercise regularly
- ☐ Swim
- ☐ Read in bed
- ☐ Needlework / crafts
- ☐ Lift weights / machines
- ☐ Jog / run
- ☐ Gym / cardio equipment
- ☐ Fall asleep in recliner / couch
- ☐ Two or more pillows
- ☐ Video games
- ☐ Computer / desk work
- ☐ Watch television

Exercise × / week | Jog × / week | Screen / game hrs per day

AUTHORIZATION AND WORKERS' COMPENSATION ACKNOWLEDGMENT

I certify that the information on this form is true and complete to the best of my knowledge. I understand that incorrect information can be dangerous to my health. I authorize Northgate Chiropractic and its providers to release information reasonably necessary for treatment, payment, and health care operations to third-party payers and other health practitioners involved in my care. I authorize and request my workers' compensation insurer / L&I (or claim administrator) to pay benefits otherwise payable to me directly to this office for services rendered. I understand that my workers' compensation claim may be denied, and if my claim is denied I agree to be responsible for payment of all services rendered on my behalf, except as limited by law or written agreement. Health information I provide may be consumer health data under Washington's My Health My Data Act (MHMDA) and is handled per the clinic's privacy practices (northgatechiro.com/privacy).

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

☐ I have read and agree to the authorization above

Patient / guardian printed name | Date

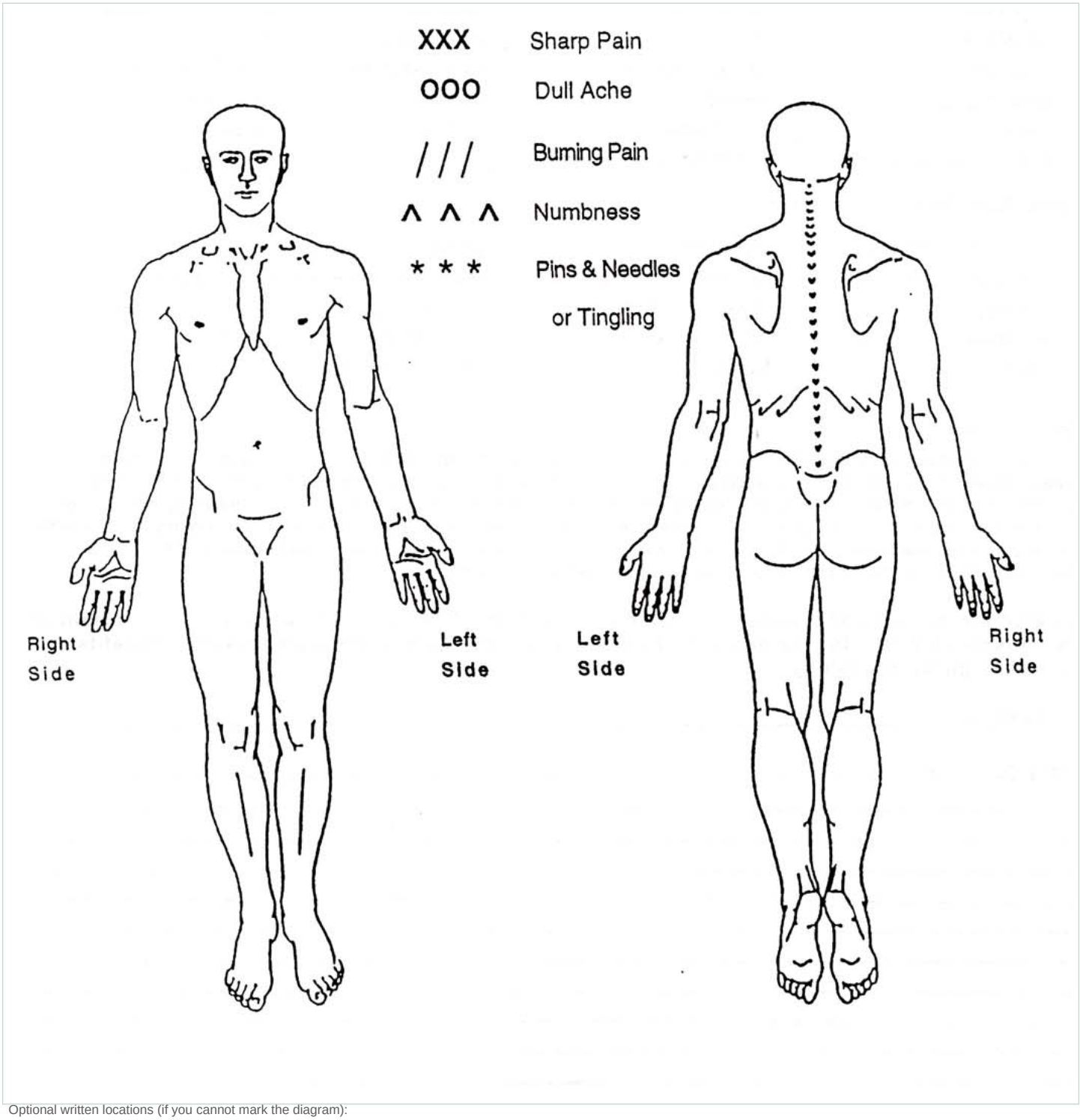
Signature (type full legal name if completing electronically)

Parent or guardian signature required if the patient is a minor.
Form version 2026-07 fillable · Original archived at public/pdfs/archive/northgate-chiropractic-workerscomp-original.pdf · © Northgate Chiropractic — clinic use

Body Diagram

Mark pain on the figures using the symbols shown · Print & pen, or use PDF draw/annotate tools

Account # _____ Last name _____ First name _____



Optional written locations (if you cannot mark the diagram):

Patient / guardian signature _____ Date _____

Parent/guardian signature if patient is a minor. Anatomy figures preserved from original clinic form (not redrawn).