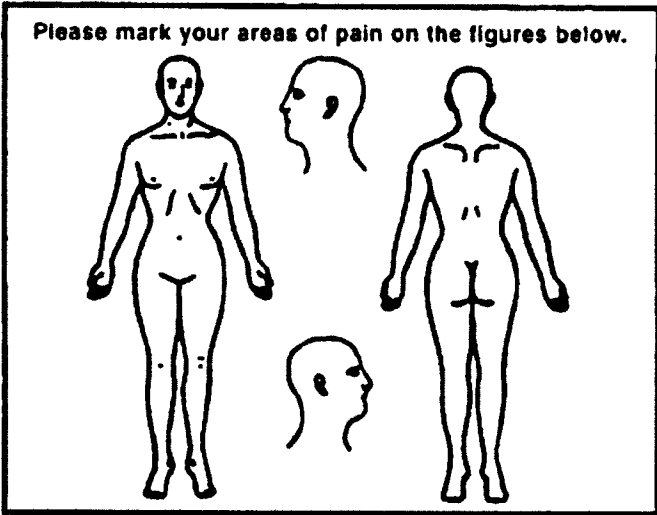


Worker's Comp Accident

Today's Date _____ Name: _____ Accident Date: _____



1. List the conditions that you are most interested in getting corrected. List in order of importance.

- 1.
- 2.
- 3.
- 4.

2. What functions are you unable to perform or induce pain upon performance? List in order of severity. (Example, sitting, bending, lying, etc.)

- 1.
- 2.
- 3.
- 4.

What Limitations have you experienced as a result of your injury? (choose all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Cannot use left arm | <input type="checkbox"/> Increased fatigability | <input type="checkbox"/> Unable to lift more than 15 pounds |
| <input type="checkbox"/> Cannot use right arm | <input type="checkbox"/> Lifting exacerbates condition | <input type="checkbox"/> Unable to lift more than 20 pounds |
| <input type="checkbox"/> Cannot use left leg | <input type="checkbox"/> Pain limits amount of movement | <input type="checkbox"/> Unable to lift more than 25 pounds |
| <input type="checkbox"/> Cannot use right leg | <input type="checkbox"/> Cannot sit due to condition | <input type="checkbox"/> Unable to lift more than 50 pounds |
| <input type="checkbox"/> Cannot drive due to condition | <input type="checkbox"/> Unable to lift more than 10 pounds | <input type="checkbox"/> Cannot walk due to condition |

Describe in detail the account of your injury:

Dates lost due to injury:

___/___/___ to ___/___/___

___/___/___ to ___/___/___

I understand the information I have provided above is current and complete to the best of my knowledge.

Signature _____