



**Houk
Chiropractic
Clinic**

Northpointe Office
9720 N. Nevada
Spokane, WA 99218
(509) 464-2273

Monroe Office
3809 N. Monroe
Spokane, WA 99205
(509) 326-3795

Accident History Form

Patient Name: _____ **Date:** _____

Describe in detail how your symptoms began: _____

_____ **Date of Injury (DOI):** _____

What was your pain level, prior to your injury/accident?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
0	1	2	3	4	5	6	7	8	9	10
No Pain										Unbearable Pain

Complete the following if your condition is related to an On The Job Injury:

Who was your employer at the time of injury? _____

How long have you worked for this employer? _____

Are you still working for this employer? Yes / No

Have you missed any time from work since this injury occurred? Yes / No # of Days? _____

Are you presently working part time? Yes / No # Hours? _____

Have your work duties been limited since the injury? Yes / No

Did you report the injury to your employer? Yes / No

Contact person who handles work related claims at your job:

Name: _____ Phone #: _____ Ext: _____

Have you ever been injured on the job before? Yes / No

How many times? _____

When was the most recent on the job injury? _____

Do you have a previous impairment rating? If yes, what? _____

Have you been seen by any other health professionals since the accident? Yes / No

If yes, Health Care Provider(s) / Facility Name: _____

Date first seen: _____

Was a claim opened by this provider? Yes / No (If yes please continue)

Date last seen: _____

Claim #: _____

Adjuster Name: _____

Address: _____

Phone #: _____

If Self Insured:

Name of Carrier: _____

Are you receiving any medication or current treatment through your MD? Yes / No

Washington L&I? Yes / No

Do you wish to transfer your care to Houk Chiropractic? Yes / No

For Office Use Only: