A: Work-related Injury Report Form

We appreciate your patience in completing this confidential questionnaire. Even if you are already a client of Burswood Health, please complete all parts of this questionnaire except your personal details (below). For new clients, please complete all sections. Ask for more paper if you need more space for any question.

PERSONAL DETAILS (only complete this if this is your first visit to this clinic or if details have changed)

Full Name ______________________ Home Phone ______________________

Address ______________________ Work Phone ______________________

Postcode ______ Mobile ______________________

Occupation ______________________ Email Address ______________________

Height ______ *cm* Weight ______ *kg* Date of Birth ______________________

Medical Practitioner ______________________ Health Cover ______________________

Marital Status ______________________ Children ______________________

Recommended by ______________________

EMPLOYMENT AND INSURANCE DETAILS (All persons to complete this section please)

Employers name: ______________________ Supervisors name: ______________________

Address: ______________________ Safety Officer: ______________________

Has this injury been reported? ☐ Yes ☐ No (tick one)

Insurance Co: ______________________ Date of Injury: ____ / _____ / _____

Address: ______________________ Time of Injury: ______________________

Describe in detail how you were injured at work…

____

____

____

____

Have you had treatment for **this** injury yet? ☐ **Yes** ☐ **No** If so, from whom? ______________________

Results of this treatment?

____

____

____

Are you currently off work ☐ **Yes** ☐ **No** If so, how long: ______________________

Your previous chiropractor/s? ______________________ Last seen? ______________________

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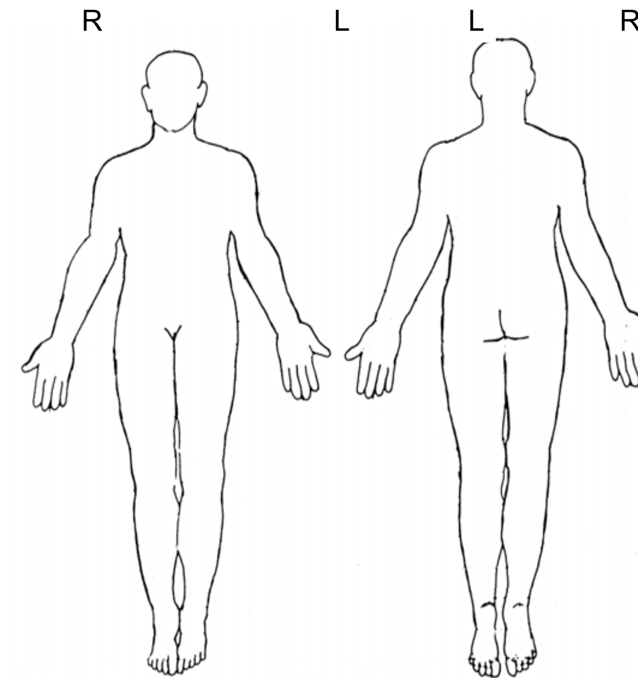
Tel: 9361 2628 Fax: 9470 1185

B: Describing your problem

Please indicate where your present symptoms are on the diagram below using the symbols on the right box.



Use these symbols to outline your problem area(s)

Aching Pain ====
====

Burning Pain xxxxx
xxxxx

Numbness or pin & needles 00000
00000

Stabbing ////////
////////

Other - *use your imagination*

Indicate the intensity of your pain on this scale: (tick one) NONE 1 2 3 4 5 6 7 8 9 10 WORST EVER

Do you have any other health problems other than those indicated in diagram above? If so, please indicate below: Tick or comment using the following table.

Nerves, muscles, bones, joints:	Lungs:
Heart, circulation:	Stomach, bowel:
Kidneys, Bladder, Reproductive organs:	Eyes, Ears, Nose, Throat:
Skin	Other

Are you currently under the care of any other health practitioners? ☐ Yes ☐ No If yes, who and what for? ______________________

The above information is correct to the best of my knowledge and I understand that providing incorrect information may affect the outcome of a claim.

Signature: ______________________ Date: __________ Witnessed: _____
(Client/Guardian signature) (CA Initials)

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