

# Healing Touch

Chiropractic,  
Sports Medicine &  
Spine Rehabilitation

Vladimir Friedman, DC, CCN, CCSP  
Jeffrey Friedman, DC, CCN  
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308 Neptune Avenue  
Brooklyn, NY 11235

## Worker's Compensation Information Sheet

Patient's name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Company Name \_\_\_\_\_ Occupation: \_\_\_\_\_

Supervisor's name \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ time \_\_\_\_:\_\_\_\_ am / pm

Have you reported this injury to your employer, in writing? \_\_\_ Yes \_\_\_ No

Explain in detail how your injury happened. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe your symptoms: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Where did you feel pain immediately after the initial incident: \_\_\_\_\_

\_\_\_\_\_

Did you return to work? \_\_\_ Yes \_\_\_ No If yes, date returned: \_\_\_\_/\_\_\_\_/\_\_\_\_

While working, do you have to favor any part of your body? \_\_\_ Yes \_\_\_ No

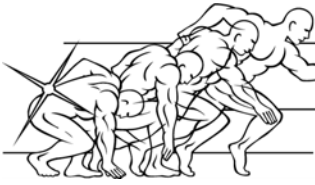
If yes, Explain \_\_\_\_\_

Are your work activities restricted presently? \_\_\_\_\_

Have you consulted another physician? \_\_\_ Yes \_\_\_ No If yes, who? \_\_\_\_\_

Treatment received \_\_\_\_\_

Have you ever had a similar condition? \_\_\_ Yes \_\_\_ No If yes, when? \_\_\_\_\_



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## Job Analysis:

What regular activities do you perform at your job?

- |   |                                    |   |
|---|------------------------------------|---|
| <input type="checkbox"/> Bending and stooping | <input type="checkbox"/> Crawling  | <input type="checkbox"/> Reaching above the shoulders   |
| <input type="checkbox"/> Squatting            | <input type="checkbox"/> Climbing  | <input type="checkbox"/> Crouching                      |
| <input type="checkbox"/> Sitting              | <input type="checkbox"/> Standing  | <input type="checkbox"/> Walking                        |
| <input type="checkbox"/> Lifting              | <input type="checkbox"/> Squatting | <input type="checkbox"/> Maintaining an awkward posture |
- Kneeling     Pushing and pulling  
 Running     Driving

How much do you regularly lift at your job?

- |  |  |  |  |  |
|--|--|--|--|--|
| <input type="checkbox"/> 1 to 10 pounds    | <input type="checkbox"/> 20 to 40 pounds | <input type="checkbox"/> 60 to 80 pounds | <input type="checkbox"/> 10 to 20 pounds | <input type="checkbox"/> 40 to 60 pounds |
| <input type="checkbox"/> 80 to 1000 pounds | <input type="checkbox"/> Over 100 pounds |  |  |  |

Are you required to regularly bend over while lifting at your job? Yes / No

Are your hands subject to repetitive movements? Such as?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Light grasping with the left hand | <input type="checkbox"/> Firm grasping with the right hand  | <input type="checkbox"/> Light grasping with both hands |
| <input type="checkbox"/> Firm grasping with the left hand  | <input type="checkbox"/> Light grasping with the right hand | <input type="checkbox"/> Firm grasping with both hands  |
| <input type="checkbox"/> Typing                            | <input type="checkbox"/> Using a computer mouse             |   |

How many hours are you required to regularly perform each of the following activities at your job?

- |                       |                        |                       |
|-----------------------|------------------------|-----------------------|
| Sitting _____ hrs/day | Standing _____ hrs/day | Walking _____ hrs/day |
| Lifting _____ hrs/day |                        |                       |

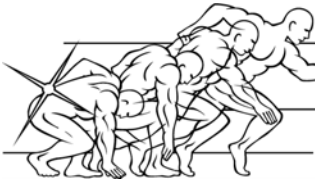
## Injuries involving Falling:

Where at work did you fall?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Onto the ground while walking                    | <input type="checkbox"/> Onto the ground while running             | <input type="checkbox"/> From a surface 1 to 3 feet off the ground |
| <input type="checkbox"/> From a surface 3 to 6 feet off the ground        | <input type="checkbox"/> From a surface 6 to 9 feet off the ground |  |
| <input type="checkbox"/> From a surface higher than 9 feet off the ground | <input type="checkbox"/> Other: _____                              |  |

What part of your body did you land on? (choose from below list)

- |  |  |                                       |                                      |                                     |   |
|--|--|---------------------------------------|--------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Head          | <input type="checkbox"/> Neck          | <input type="checkbox"/> Mid Back     | <input type="checkbox"/> Low Back    | <input type="checkbox"/> Tail Bone  | <input type="checkbox"/> Right Shoulder |
| <input type="checkbox"/> Left Shoulder | <input type="checkbox"/> Right Arm     | <input type="checkbox"/> Left Arm     | <input type="checkbox"/> Right Wrist | <input type="checkbox"/> Left Wrist | <input type="checkbox"/> Right Hand     |
| <input type="checkbox"/> Left hand     | <input type="checkbox"/> Right buttock | <input type="checkbox"/> Left buttock | <input type="checkbox"/> Right hip   | <input type="checkbox"/> Left hip   | <input type="checkbox"/> Right leg      |
| <input type="checkbox"/> Left Leg      | <input type="checkbox"/> Right knee    | <input type="checkbox"/> Left knee    | <input type="checkbox"/> Right foot  | <input type="checkbox"/> Left foot  |   |



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## Injuries involving Falling (continued):

What other areas were injured as a result of your fall? (choose from below list)

- |  |  |                                       |                                      |                                     |   |
|--|--|---------------------------------------|--------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Head          | <input type="checkbox"/> Neck          | <input type="checkbox"/> Mid Back     | <input type="checkbox"/> Low Back    | <input type="checkbox"/> Tail Bone  | <input type="checkbox"/> Right Shoulder |
| <input type="checkbox"/> Left Shoulder | <input type="checkbox"/> Right Arm     | <input type="checkbox"/> Left Arm     | <input type="checkbox"/> Right Wrist | <input type="checkbox"/> Left Wrist | <input type="checkbox"/> Right Hand     |
| <input type="checkbox"/> Left hand     | <input type="checkbox"/> Right buttock | <input type="checkbox"/> Left buttock | <input type="checkbox"/> Right hip   | <input type="checkbox"/> Left hip   | <input type="checkbox"/> Right leg      |
| <input type="checkbox"/> Left Leg      | <input type="checkbox"/> Right knee    | <input type="checkbox"/> Left knee    | <input type="checkbox"/> Right foot  | <input type="checkbox"/> Left foot  |   |

## Injuries involving Lifting:

From where were you lifting the object?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Ground level                               | <input type="checkbox"/> Below ground level                         | <input type="checkbox"/> A surface about 1 to 2 feet off the ground |
| <input type="checkbox"/> A surface about 2 to 3 feet off the ground | <input type="checkbox"/> A surface about 3 to 5 feet off the ground | <input type="checkbox"/> Other: _____                               |
| <input type="checkbox"/> A surface above 5 feet off the ground      |   |   |

How many pounds was the object you were lifting?

- |  |   |  |  |  |
|--|---|--|--|--|
| <input type="checkbox"/> 1 to 5 pounds   | <input type="checkbox"/> 5 to 10 pounds   | <input type="checkbox"/> 10 to 20 pounds | <input type="checkbox"/> 20 to 40 pounds     | <input type="checkbox"/> 40 to 60 pounds |
| <input type="checkbox"/> 60 to 80 pounds | <input type="checkbox"/> 80 to 100 pounds | <input type="checkbox"/> over 100 pounds | <input type="checkbox"/> Other: _____ pounds |  |

What position were you in while lifting the object?

- |   |   |
|---|---|
| <input type="checkbox"/> Back was in an upright/straight position | <input type="checkbox"/> Position was bent over at the waist    |
| <input type="checkbox"/> Position was twisted to the left side    | <input type="checkbox"/> Position was twisted to the right side |
| <input type="checkbox"/> Other: _____                             |   |

What type of pain did you feel immediately after the injury?

- |  |                                       |                                      |                                       |
|--|---------------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> A gripping pain   | <input type="checkbox"/> A sharp pain | <input type="checkbox"/> A dull pain | <input type="checkbox"/> An achy pain |
| <input type="checkbox"/> A popping feeling | <input type="checkbox"/> Other: _____ |                                      |                                       |

## Other work related injuries:

Other type of accident (if not caused by lifting or a fall)?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Raised up from bending over          | <input type="checkbox"/> Twisted at the waist | <input type="checkbox"/> Suffered a wrist injury from repetitive use |
| <input type="checkbox"/> Suffered a wrist injury from pulling | <input type="checkbox"/> Other: _____         |  |

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_