

Northgate Chiropractic

11065 5th Avenue NE Suite E, Seattle, WA 98125 · (206) 367-2224 · northgatechiro.com

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

Most of the day

About half 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.*

Read in bed

Fall asleep in recliner / couch

Sleep on stomach

Needlework / crafts

Two or more pillows

Sewing

Lift weights / machines

Video games

Exercise regularly

Jog / run

Computer / desk work

Swim

Gym / cardio equipment

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

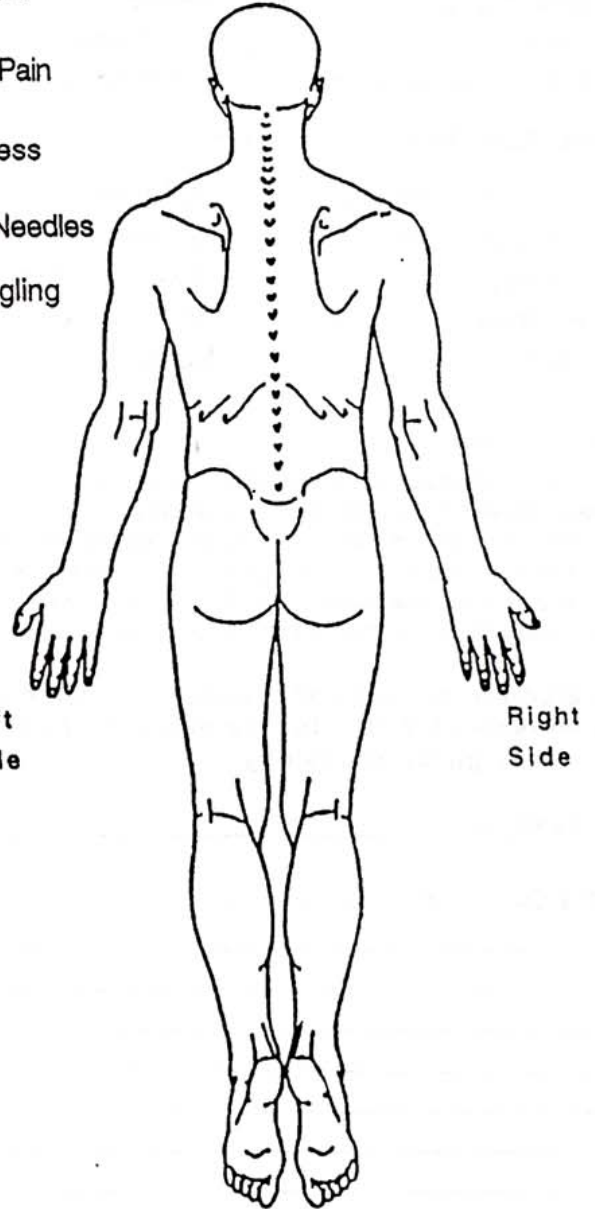
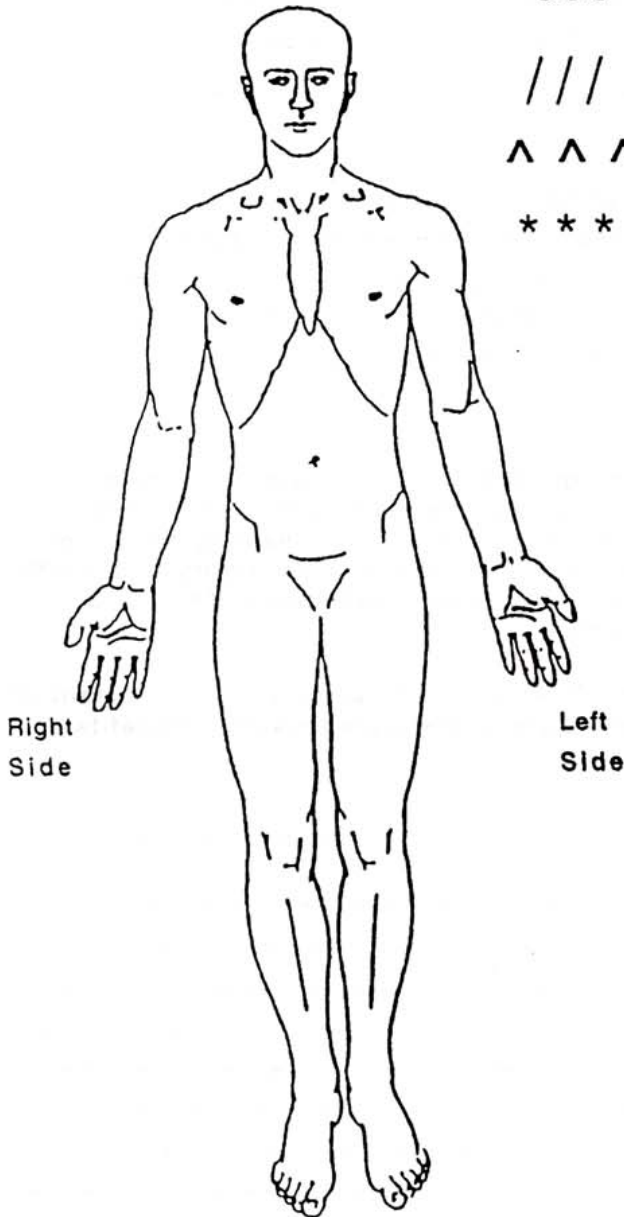
XXX Sharp Pain

OOO Dull Ache

/// Burning Pain

^ ^ ^ Numbness

*** * *** Pins & Needles
or Tingling



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).