6209 S Old Village Place, Sioux Falls, SD 57108 (605) 271-8277 Beactiveinc.com

Workman's Compensation Injury Form

Name: _____ Date: _____

Date of Injury: _____
Was your injury directly related to your work? □Yes □No

Describe the events that caused your injury: _____
Did you report your injury to your employer? □ Yes □No Was a injury report completed? □ Yes □No

Mechanism of Injury:
Was there injury to your head? □ Yes □No Loss of conscious? □Yes □No If yes, Duration? _____
Was Police at the scene? □ Yes □No Was EMS at the Scene? □ Yes □No
Did visit ER or Acute Care? □ Yes □No
If you were taken to the ER or Acute Care:
Testing Performed: _____ Treatment at ER/Acute Care: _____

Describe symptoms immediately after the injury: _____
Are there any additional symptoms felt at the time of the accident? □ Yes □No If yes, describe: _____

Are/were medications prescribed for this injury? □Yes □No
If yes, what Med: _____

Symptom status since the injury: better worse staying the same slightly better slightly worse
Functional changes since injury: worsened function at work modified work activities worsened function at home
affected ADL's affected workouts affected social activities affected sleep no change
Other: _____

Indicate **ADDITIONAL** symptoms that are a result of this accident:

□Dizziness □Chest Pain □Difficulty Sleeping □Blurred Vision □Ears Ringing/Buzzing
□Headache □Tension □Memory Loss □Shortness of Breath □Irritability
□Neck Pain □Stiff Neck □Upper/Mid Back Pain □Lower Back Pain □Back Stiffness
□Numbness Upper Extremity □Numbness Lower Extremity □Arm/Shoulder Pain □Hip Pain □Fatigue □Nausea
Other: _____

Have you obtained legal council: □Yes □No Name &Firm: _____

Financial

I have reviewed ActiveSpine's Assignment of Insurance Benefits form and agree to its terms

I understand and aware that I am ultimately fiscally responsible for any and all charges incurred with my treatment at ActiveSpine regaurdless of my insurance coverage and/or benefits.

Signature: _____ **Date:** _____