

WORKER'S COMPENSATION INFORMATION

TODAY'S DATE: ___/___/___

NAME (Last, First, Mi): _____

DATE OF BIRTH: ___/___/___ SS#: _____ - _____ - _____ HOME PHONE: _____ - _____ - _____

HOME ADDRESS: _____
Street Apt# City State Zip

EMPLOYER: _____ EMPLOYER'S PHONE NUMBER: _____ - _____ - _____

HUMAN RESOURCE CONTACT: _____ Ext: _____

EMPLOYER'S ADDRESS: _____
Street City State Zip

DATE OF ACCIDENT: ___/___/___

CHECK ONE: Full Time Employed Part Time Employed Volunteer Other: _____

HAVE YOU SEEN ANY OTHER DOCTORS/CHIROPRACTORS FOR THIS INJURY?: Yes No; If Yes, Please list doctors names & phone numbers: _____

BRIEFLY GIVE DETAILS OF HOW ACCIDENT OCCURRED: _____

BRIEFLY DESCRIBE YOUR SYMPTOMS SINCE YOUR ACCIDENT: _____

HAVE YOU FILED A WORKER'S COMPENSATION CLAIM? YES NO

HAVE YOU REPORTED THIS INJURY TO YOUR EMPLOYER? YES NO

WERE YOU TREATED WHEN THE INJURY HAPPENED? YES NO

HAVE YOU MISSED WORK SINCE THIS INJURY OCCURRED? YES NO

DOES YOUR JOB REQUIRE FREQUENT LIFTING? YES NO _____ LBS.

HAVE YOU MISSED WORK DUE TO PRIOR INJURIES? YES NO

DO NOT COMPLETE --- OFFICE INFORMATION ONLY:

WORKER'S COMPENSATION INSURANCE CARRIER: _____

INSURANCE CARRIER'S ADDRESS: _____

INSURANCE CARRIER'S PHONE NUMBER: _____

WORKER'S COMPENSATION CLAIM NUMBER: _____

SPECIFIC INSTRUCTIONS: _____

NOTES: _____

