

Worker's Injury Report

D.C. Image (R)

Please answer questions completely.

Date _____ Case No. _____

Name _____ Address _____

Street, City, State, Zip

Phone # _____ Daytime # _____ Date of Birth _____ Age _____

Sex M F Marital Status S M D W Spouse's Name _____

Social Security # _____ Number of Children _____ Occupation _____

Employer's Name & Address _____

Insurance Company _____

Referred By _____ Past Chiropractic Care Yes _____ No _____

Chiropractor's Name _____ Date of Last Visit _____

Chief Complaint: _____

Explain in your own words what happened. _____

Directly after the accident I felt _____ pain or _____ discomfort in my _____ & _____

_____ Days later I felt pain in my _____ & _____

_____ I have never had pain or complaint in this area before the accident.

Directly after the accident I was taken to _____ Hospital and received

X-Rays _____ Pain Medication _____ Muscle Relaxers _____

Other _____

_____ Days after the accident I was treated by Dr. _____ D.C., M.D., D.O.

and received _____ Medication _____ Bracing C T L Physical Therapy for _____ weeks.

Since the injury my pain/problem has been getting:

Better _____ Worse _____ Remaining the Same _____

Do you have a lawyer _____ Yes _____ No If yes, whom _____