



Worker's Compensation Intake

Patient Name: _____ Today's Date: _____

1) Date of your work injury: _____ Time: _____ am/pm

2) Employers name: _____

Employers address: _____

City, state, zip: _____

3) Attorney's name: _____

Attorney's address: _____

City, state, zip: _____

4) Describe the incident, using 1-3 complete sentences.

1. _____

2. _____

3. _____

5) After the incident, did you report the incident to your supervisor?

Yes, supervisor's name: _____

No

6) After you reported the incident, did your supervisor send you to the doctor?

Yes

a. Name of the doctor: _____

b. What did the doctor say was wrong? _____

No

7) If not, did you go to the doctor on your own?

Yes

1. Name of the doctor: _____

2. What did the doctor say was wrong? _____

No

8) Are there any other problems that effect your employment?

Yes. Describe: _____

No

9) Do you tend to favor one side of your body? yes no // If yes, left right

10) Before the injury, were you capable of equal work with others your age? yes no

11) Have you injured this area before? yes no

12) Please check the location(s) of your problem(s):

The Chiropractic Assistant will get specific information upon intake.

headaches

jaw

neck

upper back

shoulder

arm

elbow

wrist

hand

mid back

low back

hip

legs

knee

ankle

foot

other: _____