

Belleville Chiropractic Center
WORKER'S COMPENSATION HISTORY FORM

1/97

Name _____ Date _____ Case # _____

Employer at time of accident _____

Employer's phone # _____ Occupation at time of accident _____

Date of injury: ____/____/____ Approximate time of injury: _____ AM PM

Explain how the injury happened (be specific) _____

Describe the environmental conditions which may have contributed to injury: darkness, faulty equipment, slippery floor, limited space, etc. _____

Did you fill-out a work injury report? Yes No When? ____/____/____

Whom did you submit it to? _____

Were you hospitalized or evaluated at an emergency room as a result of the accident? Yes No

List ALL medical doctors, doctors of chiropractic, and physical therapist you have seen since the accident:

_____, _____
_____, _____

Were you taken off work or given any work restrictions as a result of the injury? Yes No

Are you currently on any work restriction? Yes No If yes, by whom? _____

If yes, what are the restrictions? _____

Are you having any problems with a fellow employee or supervisor in regards to your injury? Yes No

If yes, what? _____

Did you have any physical problems or symptoms just before the accident? Yes No

If yes, what? (be specific) _____

Prior to this accident, have you ever injured or had symptoms in the area of your body now affected? Yes No

If yes, what and when? (be specific) _____

Due to physical problems or symptoms, are your daily activities different since the accident? Yes No

If yes, what are you now unable to do? _____

If yes, what is now painful or difficult to do? _____

Do you have an attorney on this case? Yes No

If yes, Name _____ Phone # (____) _____-_____

My signature below verifies that I have read, understood and truthfully answered each question to the best of my ability.

Patient's Signature: _____ Date: _____