WORKER'S COMPENSATION FORM

Patient Information:

Patient Name: ____ Date: ____ / _____ / ______

Occupation: ____

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Employer Information:

Employer's Name: ____ Employer's Phone: ____ / _____ / ______

Employer's Address: ____

Contact Person: ____ Claim Number: ___________________________

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Work Injury Information:

Date of Injury: ____ / _____ / ______ Place of Injury: _____________________________________

Reported to Employer / Supervisor: ___Yes ___No If Yes, Name reported to: _____________________________________

Please explain how the injury happened: ____

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____

Do you go the ER or any hospitals? ___Yes ___No

If Yes, which one: ____

Have you lost any time from work since the injury? ___Yes ___No

If Yes, how much: ____

Have you seen any other doctors for this injury? ___Yes ___No _____MD ___PT ___Ortho ___Other:_______________

Were any X-rays or other tests performed? ___Yes ___ No

If yes, Please explain the findings: ____

Have you ever had any previous Work Injuries? ___Yes ___No

If yes, please explain: ____

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Are you taking any medications now for your recent injury?

___ Pain killers ___ Anxiety meds. ___ Vicodin ___ Tramadol ___ Morphine ___Advil

___ Muscle relaxers ___ Oxycodone ___ Hydrocodone ___ Fentanyl ___Acetaminophen

___ Other: ______________________________

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Please describe the type of pain you are having:

___ dull ___ achy ___ sharp ___Stiff

___ Shooting ___ Radiating ___ Burning ___ Tight

___ Numbness ___ Tingling ___ stabbing

How often are your current symptoms:

___ constantly (76-100%) ___frequently (51-75%)

___ occasionally (25-50%) ___ Intermittent (25% of less)

___ coming and going (with certain actions / movements)

Are your symptoms changing:

___ better ___same ___ getting worse

If worse, how long? _______________________

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Did your injury involve lifting? ___Yes ___No

(If Yes Please complete.)

From where were you lifting when the injury occurred?

___Ground level ___below ground level ___ 1-3 ft high

___3-5ft high ___above 5 ft high ___above your head

How many pounds was the object you were lifting?

___ 1-5 pounds ___5-10 pounds ___10-20 pounds

___20-50 pounds ___Over 50 pounds

Did your injury involve falling? ___Yes ___No

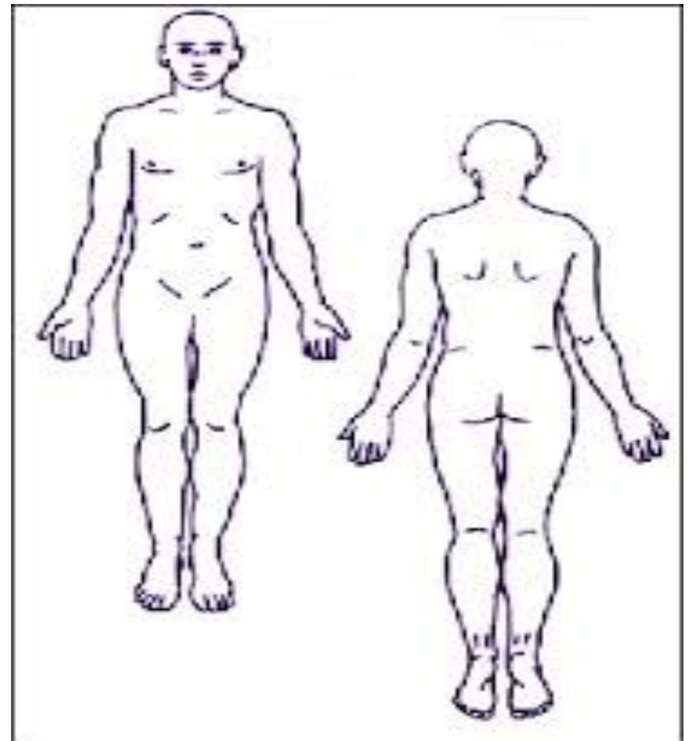
(If Yes Please explain)

___On the ground from walking ___On the ground from running

___From 1-3 feet ___From 3-10 feet ___Over 10 feet

What part of your body did you land on? _____________________

Please circle the areas of compliant:



Please grade you pain / symptoms: 0 1 2 3 4 5 6 7 8 9 10

(0=no pain) (10=severe pain)

Please circle the things that aggravate you condition:

Bending / lifting / twisting / pushing / pulling / driving / sitting / standing / sleeping / walking

Exercising / cleaning / sports / overhead work / computer work / carrying child / driving / working

Please circle the things that relieve your condition:

Ice / heating pad / resting / lying down / medications / sitting / stretching / exercises / massage / chiropractic

Please note that all patients are required to have an examination for determining if chiropractic care is warranted for your condition noted today. With my signature, I agree to allow Denn Chiropractic LLC, to use all chiropractic means to determine my care.

Name:____ **Date:** _____ / _____ / ______