WORKERS' COMPENSATION HISTORY

Adirondack Chiropractic
587 Main St. NY Mills NY

James G. Kolwaite DC.
315-768-7578

Name: ____ Age: ________ Date of birth: _____/____/____ Date______________

Address: ______________________________________ City: _______________________ State: _______ Zip: _______________

Social Security #: ________________________________ Telephone#_____________________ Cell#________________________

Employer's Name: ____ Telephone #: ___________________________________

Address: ______________________________________ City: _______________________ State: _______ Zip: _______________

Carrier's Name: ____ Telephone #: ___________________________________

Address: ______________________________________ City: _______________________ State: _______ Zip: _______________

Have you retained legal counsel for this injury? ☐ Yes ☐ No If yes, give name and address: ____________________________

____

INJURY DESCRIPTION

Date present injury was received: ____/____/____ Time of injury: _________ ☐ AM ☐ PM

Who saw the accident? Name: ____ Title: __________________________

Who reported the accident? Name: ____ Title: __________________________

What medical attention was rendered? ____

By whom? ☐ Nurse ☐ MD ☐ DO ☐ DC ☐ Other employee ☐ Other ____

How did the injury occur? ____

Chief complaint: ____

Symptoms: ____

Since the injury, are your symptoms ☐ Improving ☐ The same ☐ Getting worse

In your job, do you push or pull? ☐ Yes ☐ No If yes, give specifics: ____

If your work is at a desk, give specifics of job, computer, typewriter, business, machines, phone, etc. ___________________________

____

Do you carry anything or pick anything up? ☐ Yes ☐ No If yes, what? ____

PREVIOUS WORK HISTORY

Give a job description of services or work performed for each job classification or source of employment for the preceding ten (10) years.

1. ____

2. ____

3. ____

4. ____

Have you ever applied for Workers' Compensation benefits before? ☐ Yes ☐ No Date: ____/____/____

Reason: ____

Was there a time loss from work? ☐ Yes ☐ No From: ____/____/____ to ____/____/____

State the degree of recovery: ____

PRESENT WORK HISTORY

What is the job classification of your normal job? ____

Were you performing your normal job? ☐ Yes ☐ No

How long have you been at your present job? ______________ Average work week ______________ hours _______________ days

Has there been a time loss or absenteeism caused from job injury? ☐ Yes ☐ No If yes, explain: ________________________

WORKERS COMPENSATION HISTORY PART 2

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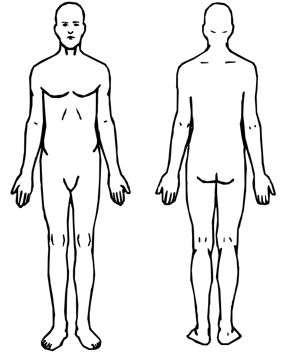
MEDICAL HISTORY

Please list any current medical conditions____

Please list any medications____

Please list any surgeries ____



Please indicate on the figures to the right where your pain and / or dysfunction is ,--------------------→

Additional Information

____

____

____

____ ___________________

Patient Signature Date

____ ___________________

Staff Signature Date

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