Northwest Family
CHIROPRACTIC & MASSAGE

Work-Related Accident Complaint

Patient Name:_____ Date:_____

Date of Injury:_____ City, State Accident Occurred:_____

L&I Claim: State / Private / I don't know

Do you have an open L&I claim for this work-related injury? □ yes □ no
If Yes, Claim #: _____
Adjuster Name: _____
Adjuster Phone #: _____

Have you reported this accident to your supervisor? □ yes □ no

Supervisors name: _____ Phone # _____

Have you ever injured yourself at work before? □ yes □ no
If yes, when: _____

Have you ever experienced this symptom before? □ yes □ no
If yes, explain: _____

In your own words, please describe the accident:

_____

_____

Have you seen any other provider? □ yes □ no
If yes, please list:

Name:_____ Phone #: _____

Name: _____ Phone #: _____

Please list any other treatment/care you have had for this injury:

_____

_____