

KANADY

CHIROPRACTIC CENTER

Patient Name: _____ Date: _____

“ON THE JOB INJURY”(workers compensation)

Date injured _____ Hour of injury _____ AM PM

Was your accident directly related to your work? Yes No

Give the address where the accident occurred (Was this at employers address?) Yes No

Briefly describe the events that occurred just before and during your accident _____

What symptoms do you have as a result of your injury? _____

Did the accident render you unconscious? Yes No If yes, for how long? _____

Did you require hospitalization? Yes No Hospital Name _____

When did you go? Directly After Accident The Next Day 2 Days Plus

How did you get there? Ambulance Private Transportation

Where X-Rays Taken? Yes No Was Medication Prescribed? Yes No

Are your work activities restricted as a result of this injury? Yes No

Have you lost any days of work? Yes No Dates _____ Date Last Worked _____

Was anyone else present during your accident? Yes No

Did you report the injury to your foreman or employer? Yes No

Did he/she /they recommend care at our clinic? Yes No

Have you contacted an insurance adjuster or company representative regarding this claim? Yes No

Do you have an attorney that has advised you in this case? Yes No

Attorney's Name _____ Telephone _____

Address _____

Have you ever had an injury to the **same area** where you are now hurting? Yes No

If “Yes” state **when** and **how** you were injured _____

To the best of your knowledge, has this accident occurred in your workplace before? Yes No

Any other pertinent information to your injury _____