

Bakke Chiropractic Clinic
Worker's Compensation History Form

Name: _____ Date _____ Case# _____

Date of injury: _____ Approx. time of injury: _____ am pm

Your occupation: _____

Explain how the injury happened (be specific) _____

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

Did you seek any treatment prior to today as a result of the injury? Yes No

Please explain: _____

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

Are you currently on any work restriction? Yes No Please explain: _____

Prior to this incident have you ever been injured /or had symptoms in the area now affected? Yes No

If yes, please explain (be specific) _____

Are your daily activities different since this injury? Yes No Please explain: _____

Have you contacted an Attorney? Yes No

EMPLOYER COMPENSATION INFORMATION

Employer's Name: _____

Employer's Address: _____

Person to Contact: _____ Phone #: _____

Patient's Social Security Number: _____

Did you report the injury: Yes No If yes, reported to?: _____ Phone#: _____

Did you fill out a work injury report and turn it in? Yes No

<p>For Office Use Only</p> <p>Employer called: _____</p> <p>Has injury been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Work comp carrier? Carrier Address:</p> <p>Phone#: Claim # (assigned): Date of injury:</p>
--

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

Patient's Signature: _____ Date: _____