Chart#_____

BAKKE CHIROPRACTIC

Worker's Compensation History Form

Patient Information

Last Name: _____ First Name: _____ M.I.: _____

Social Security #: _____-_____-_____ Date of Injury: _____ Time of Injury: _____ AM/PM

Your Occupation: _____

Accident Details

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 because of the injury? No _____ Yes _____ If yes, please explain: _____

_____

Were you taken off work or given any work restrictions because of the injury? No _____ Yes _____ If yes, please explain:

_____

Are you currently on any work restrictions? No _____ Yes _____ If yes, please explain: _____

_____

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

If yes, please explain (be specific): _____

Are your daily activities different since this injury? No _____ Yes _____ If yes, please explain: _____

_____

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

Do you have an attorney? No _____ Yes _____ If yes, Attorney Name: _____

Attorney Phone #: _____

Employer Information

Employer's Name: _____ Contact Person: _____

Employer's Address: _____ Contact Person Phone: _____

_____

Office Use Only

Work Comp Carrier: _____ Adjustor Name: _____

WC Carrier Address: _____ Adjustor Phone #: _____

_____ Claim Number: _____

Patient/ Guardian Signature: _____ **Date:** _____