Adjustin Chiropractic
Work Related Injury Sheet

Name _____

Social Security # _____

Today's Date _____

Date of Injury _____

Time of Day of Injury _____ [ ] A.M. [ ] P.M.

Employer at time of Injury _____

Phone _____

Was injury reported to your employer? Y N

Name of person reported to: _____

Position _____

Are you or were you off work? Y N

If yes, last day worked? _____

If you have since returned to work, when did you return? _____

When you returned to work, did you have restrictions? Y N

If yes, what were they? _____

Are you currently working with restrictions? Y N

Type of work being done at time of injury? _____

In your own words, describe the accident in detail

_____

_____

_____

Prior to this accident, have you ever had any of the physical complaints you now have? Y N

If yes, describe _____

Were these similar complaints the result of previous accidents? Y N

Have you received a medical discharge from the Armed Services? Y N

Do you have to bend over while doing any lifting? Y N

Are your feet used for repetitive movement, such as operating foot controls? Y N

Are you required to be around moving machinery? Y N

Are you exposed to marked changes in temperature and humidity? Y N

Are you required to drive automobile equipment? Y N

Have you been treated by another doctor for this injury? Y N

If yes, state doctor's name and treatment received _____

Do you have an attorney? Y N If yes:

Name _____ Phone _____

Address _____ City _____ State _____

If this is an old claim, please list your claim # _____