

DeCrescenzo Chiropractic

Worker's Compensation Form

Date: _____/20_____ Referred by: _____
Full Name: _____ S.S. #: _____
Age: _____ Date of Birth: _____ Gender: _____ Marital Status: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: (____) _____ Cell Phone: (____) _____ Email: _____
Occupation: _____ Employer: _____ Work Phone: (____) _____
Emergency Contact: _____ Phone: _____
Relationship to you: _____ May we contact them: YES / NO
Primary Care Physician: _____
Address: _____ Phone # _____

WORK RELATED INJURY

Date of accident: _____ Type of accident: _____
What state do you work in? _____
Are your symptoms solely the result of a work related injury? YES/ NO
Please describe how the accident occurred:

Did you experience immediate pain following the accident? YES/ NO
Are you symptoms getting worse? YES / NO Are they: CONSTANT / COMES & GOES
What were your symptoms at that time:

Did you seek treatment at the Hospital or Medical Center? YES / NO
Where _____ When? Same Day /Next Day/ Date: _____
Were you transported by ambulance? YES / NO
Were any test performed at the medical facility?
• XRAYs/ MRI/ CT SCAN Which body part: _____
• BLOODWORK: YES / NO

SOCIAL HISTORY:

Are you a smoker? YES / NO If yes, how much? _____
Do you drink any alcohol? YES / NO How often: Socially/ Occasionally/ Weekly/ Daily

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INSURANCE & ATTORNEY INFORMATION:

Do you have an Attorney? If yes, what is his/her name? _____

What is the name of the Worker's Compensation insurance? _____

Do you have a claim number? (Please provide) _____

Did you file an injury report with your employer following the accident? YES / NO

What symptoms/injuries did you report initially? _____

Do you have health insurance? If yes, which? _____ Please give your card to the front desk.

SYMPTOMS/ INJURIES:

What are your symptoms: Please circle

Headaches Neck pain Neck stiffness Jaw problems

left/right Arm pain left/right Shoulder pain

left/right Hand/finger pain/numbness Mid-back pain Back stiffness

Chest pain Low back pain left/right Leg pain

left/right Knee/Ankle pain left/right Foot/Toe pain/numbness

Dizziness Nausea Fatigue Sleep difficulty Abdominal pain

Difficulty turning head to the right/left Vision blurred Hearing loss / Balance

On a pain scale of 1 thru 10, 1 being almost no pain and 10 being the greatest, what would you rate your pain level today? _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, ever have a change in health.

Signature of patient or Personal Representative

Date

Please print name of patient or Personal Representative

Date