Family Chiropractic
& Occupational
Health Services
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WORKMAN'S COMPENSATION

Name _____ Sex _____Age _____
Address_____
Employer Name _____Phone _____
Employer Address _____
Date and time of accident?___ _____
Where were you taken after accident? _____
Where did you feel pain? _____
What are your symptoms? _____
Other doctor(s) consulted since your accident _____
Treatment received _____
How often did you receive care from other doctor(s)? _____
Did you miss any work? _____ Date Returned to work _____
Are your work activities restricted as a result of an accident? _____
Have you previously been injured in a similar manner? _____
If so, when? _____
Have you any other disease or accidents that affect your employment? _____
Do you have to favor any part of your body during employment? _____What?_____
History of absenteeism caused from accidents on the job? _____

_____

Were you capable of working on an equal basis with others your age before your accident?_____
What is present occupation? _____
Length of present occupation _____
Since the injury are your symptoms: Improving _____ Getting Worse _____ Same ____
Have you retained an attorney? _____
If so, attorneys name, address, and phone number_____

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