Workers Comp Form

Date_____

Name_____ Gender: ☐ Male ☐ Female D.O.B____/____/_____

Your Social Security #_____-_____-_____

Workers Comp Insurance

Your WC Claim #_____ Date of Injury: _____/_____/_____

Insurance Company Address _____

Your WC Case Manager_____ Phone # (_____)_____-_____

Employer Name_____

Employer Address _____

Contact person at work_____ Phone # (_____)_____-_____

Employer WC Insurance Company_____

Do you have any previous Workers Compensation claims? Yes / No

If yes, where and when? _____

Have you been treated by any other PT or Chiropractor for this WC injury? Yes / No

If yes, where and when? _____

Date of Injury: _____ **Please explain how you were injured:** _____

_____

_____

Please answer the following questions:

1. When and where did you feel any pain? _____

2. Did you get medical attention? Yes / No If yes, who treated you? _____

3. What treatment did you receive? _____

4. Did you have any xrays or MRI taken? Yes / No If yes, where? _____

5. Did you return to work? Yes / No. If no, how many days have you been out of work? _____

6. Are your work activities restricted as a result of this accident? Yes / No

7. Since this injury, are your symptoms: Getting Worse, Getting Better, Staying the Same (circle one)

8. On a scale of 1-10 with 10 being the worst, how do you rate your pain today? _____

Name, Address, Phone # of your Attorney _____

_____

Signature: _____Date: _____/_____/_____