WORKER'S COMPENSATION/ACCIDENT FORM

Today's Date_____
Name:_____Age:_____Date of Birth_____ M F
Address:_____
City:_____State:_____Zip:_____
SS#_____Driver's License #:_____

Date of injury:_____
Were you hospitalized? (circle one) Yes No If yes, for how long?_____
Did you receive care from any other health care specialist? (circle one) Yes No If yes, what is the specialist's name?_____
What type of care were you given, and for how long?_____

Please describe how the accident happened:_____
_____
_____
_____

Name and address of employer_____
_____
Did he or she refer you to our office? ( ) Yes ( ) No
List the extent of the injuries as you know them: _____
_____
_____
Have you lost any days of work?_____
Insurance company and address:_____
_____
_____
Policy number:_____
Claim number:_____

SYMPTOMS:
Please check symptoms you have noticed recently:

( ) Headaches	( ) Dizziness	( ) Light bothers eyes	( ) Diarrhea
( ) Back Pain	( ) Head seems heavy	( ) Loss of memory	( ) Cold feet
( ) Neck stiff	( ) Pins and needles in arms	( ) Ringing in ears	( ) Cold hands
( ) Sleeping Problems	( ) Pins and needles in legs	( ) Face flushed	( ) Upset stomach
( ) Neck pain	( ) Numbness in fingers	( ) Buzzing in ears	( ) Constipation
( ) Nervousness	( ) Numbness in toes	( ) Loss of balance	( ) Cold sweats
( ) Tension	( ) Shortness of breath	( ) Fainting	( ) Fever
( ) Irritability	( ) Fatigue	( ) Loss of smell	( ) Loss of taste
( ) Chest pain	( ) Depression	( )_____	( )_____

List any other symptoms not listed above_____
_____