Worker's Compensation Injury Form

Name: __________________________________ Today's Date:______________

Date of Accident: ______________________________________ Time:___________________

Have you filled out your "First Report of Injury Form" at Work? Yes No

Is your injury affecting your ability to do your job at work? Yes No

Do you need a note for work? Yes No

What were you doing at the time of the accident? ____

Did you trip, slip, or fall? ___________________________ How far was the fall ? ________________

Upon impact after slip, trip, or fall, how did your body land? ____________________________________

Were you lifting an object? _________________________ How heavy was the object? _____________

Were you twisting or bending? Yes No

Did you hit your head on anything? Yes No On What? ________________________________

Did you lose consciousness? Yes No For how long? ___________________________________

When did the pain begin?____

Since accident pain is : Less _____________ Same ___________________ Worse ______________

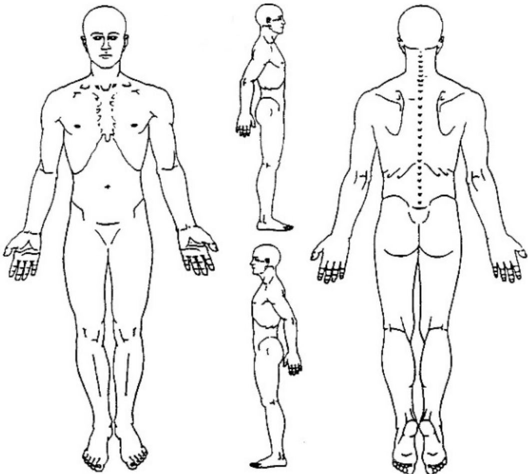
Were you transported to hospital? Yes No Which hospital? _______________________________

Were x-rays taken ? Yes No What x-rays ? ____

Have you seen another doctor since the accident? Yes No Name of Dr.____

What treatment did you receive?____

Were there any suggested future treatment plans? ____



← Please indicate on the body where your pain is

On a scale from 0-10, with 10 being the worst pain, and 0 being no pain, what is your current rating of pain?

0 1 2 3 4 5 6 7 8 9 10

I understand that if for some reason my worker's compensation claim does not pay for this treatment, I am fully responsible for the cost of my treatment received at Perreault Chiropractic & Acupuncture.

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Patient signature