FRYEBURG CHIROPRACTIC & WELLNESS CENTER

Worker's Compensation History

Name_____ DOB_____ SSN_____

Address_____ City_____ State_____ Zip_____

Employer_____ Supervisor_____

Employer Address_____ Phone_____

Was a pre-employment exam performed? _____ Yes _____ No

If so, Date_____ Doctor_____ Place_____

Insurance carrier and address _____

Date, time, and place of injury _____

Has this injury been reported to your employer? _____ Yes _____ No

Description of incident _____

What medical attention was rendered and by whom? _____

_____

Chief complaint / symptom_____

Prior to this accident, have you had physical complaints similar to your present complaints?
_____

If so, please describe _____

Have you been out of work because of this accident? _____ Yes _____ No

If so, for how long? _____ Dates _____

Have you retained legal counsel for this injury? _____ Yes _____ No

Name and address _____

Signature _____ Date _____

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