ROCKSIDE CHIROPRACTIC WORK INJURY REPORT

Date of Accident: _____ _____ Time Of Accident: _____

Date Last Worked: _____ Days Missed: _____

Employer: _____ Type Of Business: _____

Was the accident reported to your employer? Y N

Was a Worker's Comp Claim filed? Y N

Was there any equipment, machinery and/or object part of the accident? Y N

What kind? _____

Have you ever had a Workers Compensation Claim before? Y N

List any prior work related
injuries:_____
_____

Provide a detail describe of your accident? _____
_____
_____

Have you consulted any other doctors for this injury? Y N If yes please give name and phone
number:_____
_____

Did you have physical complaints prior to the accident? _____

What symptoms did you feel during the accident? _____

What symptoms did you feel the next day? _____

Since the injury what are your complaints? _____

Are you aware of any congenital problems or previous illness related to your
injury?_____

Have you ever injured this area before? Y N If yes, When? _____

If injured before did you miss any work? _____

Have you ever been involved in any other type of accident, fall or broken bones? _____

_____

I understand and agree that health and accident policies are an arrangement between an insurance company and myself. Furthermore, I understand that the office will prepare any necessary reports and or forms to assist me in making any collections from the insurance company and that any authorized amount that is paid directly to the office will be credited to my account. Upon receipt permit this office to endorse co-issued remittances for the conveyance of credit to mu account. However, I clearly understand and agree that all services rendered be charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment and fees for services rendered to me will be immediately due.

Patient's Signature: _____Date: _____

Doctor's Signature: _____Date: _____