WORK RELATED ACCIDENT INFORMATION

Name: _____ Age_____ DOB: _____

Address: _____ City/State/Zip_____

SS#_____

Home phone (_____) _____Work phone (_____) _____ Cell phone (_____) _____

ACCIDENT INFORMATION: Date: _____ Time:_____ Employer or Supervisor report made?_____

Name of Employer: _____ Address:_____

Description of accident: _____

_____

Were you injured? Y ( ) N ( ) How? _____

Were you unconscious? Y ( ) N ( ) Fractures Y ( ) N ( ) Cuts Y ( ) N ( ) Abrasions Y ( ) N ( ) Bruises Y ( ) N ( ) Concussion Y ( ) N ( )

Did you go to the hospital? Y ( ) N ( ) by Ambulance Y ( ) N ( ) which hospital? _____

Seen by which doctor? _____ What treatment did you receive? _____

Diagnosis?_____

WHAT ARE YOUR PRESENT COMPLAINTS? 1._____

2. _____ 3._____

4. _____ 5._____

On a scale of zero to ten with zero being no pain and 10 the worse pain you can imagine how would you score your pain today? _____

What other treatment have you received for this injury? _____

Have you seen other physicians for this problem? If so who? _____

What was their diagnosis?_____Treatment?_____

Have you had similar problems in the past? _____ When _____ Treated by: _____

I hereby state that the information on this form is true and correct. I authorize Birdwell Chiropractic Clinic to examine, x-ray, and treat me in whatever way they deem necessary in accordance with state statutes for the care and management of my condition. I understand and agree that Workers Compensation insurance policies are an arrangement between an insurance carrier and my employer. Furthermore, I understand that the Birdwell Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized is to be paid directly to Birdwell Chiropractic Clinic which will be credited to my account. However, I clearly understand and agree that all services rendered to me are 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 any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature:_____ Date:_____

Parent, Guardian or Spouse's Signature Authorizing Care: _____ Date:_____