Bakke Chiropractic Clinic
Worker's Compensation History Form

Name:_____ Date_____ Case#_____

Date of injury:_____ Approx. time of injury:_____ ☐ am ☐ pm

Your occupation: _____

Explain how the injury happened (be specific)_____

_____

_____

Describe the environmental conditions which may have contributed to your injury (darkness, faulty equipment, slippery floor, limited space, etc):_____

_____

Did you seek any treatment prior to today as a result of the injury? ☐ Yes ☐ No

Please explain:_____

Were you taken off work or given any work restriction as a result of the injury? ☐ Yes ☐ No

Are you currently on any work restriction? ☐ Yes ☐ No Please explain: _____

_____

Prior to this incident have you ever been injured /or had symptoms in the area now affected? ☐ Yes ☐ No

If yes, please explain (be specific)_____

Are your daily activities different since this injury? ☐ Yes ☐ No Please explain: _____

_____

Have you contacted an Attorney? ☐ Yes ☐ No

EMPLOYER COMPENSATION INFORMATION

Employer's Name:_____

Employer's Address:_____

Person to Contact: _____ Phone #: _____

Patient's Social Security Number:_____

Did you report the injury: ☐Yes ☐ No If yes, reported to?:_____ Phone#: _____

Did you fill out a work injury report and turn it in? ☐Yes ☐ No

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For Office Use Only

Employer called: _____

Has injury been filed? ☐ Yes ☐ No

Work comp carrier?
Carrier Address:

Phone#:
Claim # (assigned):
Date of injury:

My signature below verifies that I have read, understood and truthfully answered each question to the best of my ability.

Patient's Signature:_____ Date:_____