

# AUTO ACCIDENT HISTORY

**WELCOME.** The doctor and staff of *On-Site Mobile Chiropractic* welcome you and want you to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will refer you to the appropriate healthcare provider. If you are a candidate for chiropractic care; a treatment plan will be recommended to fit your individual needs.

**INSTRUCTIONS.** Please complete questions 1 through 67 to the best of your ability. Be as descriptive as possible and check all descriptors that apply. This form was designed to reduce the time involved in taking your initial history. In doing so, we are able to spend more time on determining the nature of your current problem through examination procedures. If you have questions, please ask a staff member for assistance or clarification. Please inform the doctor if there are circumstances surrounding your accident that are not covered here and that you feel would be helpful.

Name \_\_\_\_\_ Today's Date      /      /

## HISTORY OF OCCURRENCE

Date of the Accident      /

1. I was the/a:     Pedestrian       Driver       Passenger- Left Front       Passenger- Center Front  
                   Passenger-Right Front       Passenger-Left Rear       Passenger-Center Rear  
                   Passenger-Right Rear
- a. What was your point of impact?  Head-On  Rear-End  Left Front  Left Rear  Right Front  Left Front
- b. Did you feel pain immediately following the accident?  Yes  No    If you answered no how long after the accident was it before the pain started?     30min-1 hr     1 -4 hours     4 -12 hours     12 -24 hours     \_\_\_\_\_ Days
- c. Where did you go after the accident?     Home     Work  Hospital ER  Private Doctor
- d. Did you receive any of the following:     x-ray  CT Scan  MRI  Lab work  Treatments/Medications
- e. How did you get there? ?     Drove self     Somebody else  Ambulance  Police     Other: \_\_\_\_\_
- f. List any doctors you've seen prior to this first visit to our office, their specialty, and any treatments received:

## 2. Patient Vehicle Type (What type of car were you driving?)

- Compact       Mid-size       Full-size       SUV       Pick-up       Motorcycle       Other \_

## 3. Second Vehicle Type (What was the opposing car type?)

- Compact       Mid-size       Full-size       SUV       Pick-up       Motorcycle       Other \_

## 4. Third Vehicle Type:

- Compact       Mid-size       Full-size       SUV       Pick-up       Motorcycle       Other \_\_\_\_

## 5. Road Conditions:

- Dry       Icy       Wet       Clear       Foggy       Dark       Other

## 6. Road Type:

- Concrete       Asphalt       Gravel       Dirt       Other \_\_\_\_\_

7. Were you aware the accident was going to occur?     Yes       No

8. Were you wearing a seatbelt?     Yes       No

9. Did your airbag deploy?     Yes       No

10. Does your car have a headrest?     Yes       No

11. What position was the headrest in?     Up     Middle       Down

12. Head Position: (At the time of the accident were you looking...)     Straight Ahead       Left Level

- Left Up       Left Down       Right Level       Right Up       Right Down       Looking Up  
 Looking Down

13. Were you pushing the brake (stopping) either during or before impact?  Yes  No
14. Was your car moving before impact?  Yes  No  
If yes, how fast? (mph)  <5  6-10  11-15  16-20  21-30  31-40  41-50  51-60  61-70  >70
15. Was the driver of the second vehicle braking (stopping)?  Yes  No
16. Was the second vehicle moving before impact?  Yes  No  
If yes, how fast? (mph)  <5  6-10  11-15  16-20  21-30  31-40  41-50  51-60  61-70  >70
17. Was the driver of the third vehicle braking (stopping)?  Yes  No
18. Was the third vehicle moving before impact?  Yes  No  
If yes, how fast? (mph.)  <5  6-10  11-15  16-20  21-30  31-40  41-50  51-60  61-70  >70

**COLLISION DETAILS** (*Describe how the cars collided. My vehicle was...*)

19. First Impact:  Hit By Another Vehicle  Hit Another Vehicle  Hit By An Object  
 Hit An Object
- (My car was hit in the...)  Front  Front-Right  Front-Left  Left  Right  
 Right-Rear  Left-Rear  Rear  Top
20. Second Impact:  Hit By Another Vehicle  Hit Another Vehicle  Hit By An Object  
 Hit An Object
- (My car was hit in the...)  Front  Front-Right  Front-Left  Left  Right  
 Right-Rear  Left-Rear  Rear  Top

**COLLISION RESULTS** (*"During the accident my..."*)

21. Body was thrown:  Backward  Forward  Left  Right  Can't Remember
22. Head Hit:  Airbag  Another Person's Body  Back Of Front Seat  Dashboard  
 Front Windshield  Rear-View Mirror  Side Window/Door  Steering Wheel  
 Windshield
23. Chest Hit:  Another Person's Body  Back Of Front Seat  Dashboard  Side Window/Door  
 Steering Wheel
24. Shoulders Hit:  Another Person's Body  Back Of Front Seat  Shoulder Harness  
 Side Window/Door
25. Knees Hit:  Another Person's Body  Back Of Front Seat  Center Console  Dashboard  
 Door Panel  Steering Wheel
26. Hips Hit:  Another Person's Body  Back Of Front Seat  Center Console  Dashboard  
 Door Panel  Steering Wheel

If other area then describe: \_\_\_\_\_

**VEHICLE DAMAGE**

27. First Vehicle:  Totaled  Significant Damage  Light Damage  No damage
28. Second Vehicle:  Totaled  Significant Damage  Light Damage  No damage
29. Third Vehicle:  Totaled  Significant Damage  Light Damage  No damage

**PERSONAL INJURY**

30. Were you hospitalized?  Yes  No (*If yes, please answer the questions in the paragraph below.*)
- ⇒ When were you hospitalized?  Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Immediately  Later The Same Day  The Next Day.
- ⇒ How were you transported to the hospital?  Ambulance  Life Flight  Private Transportation

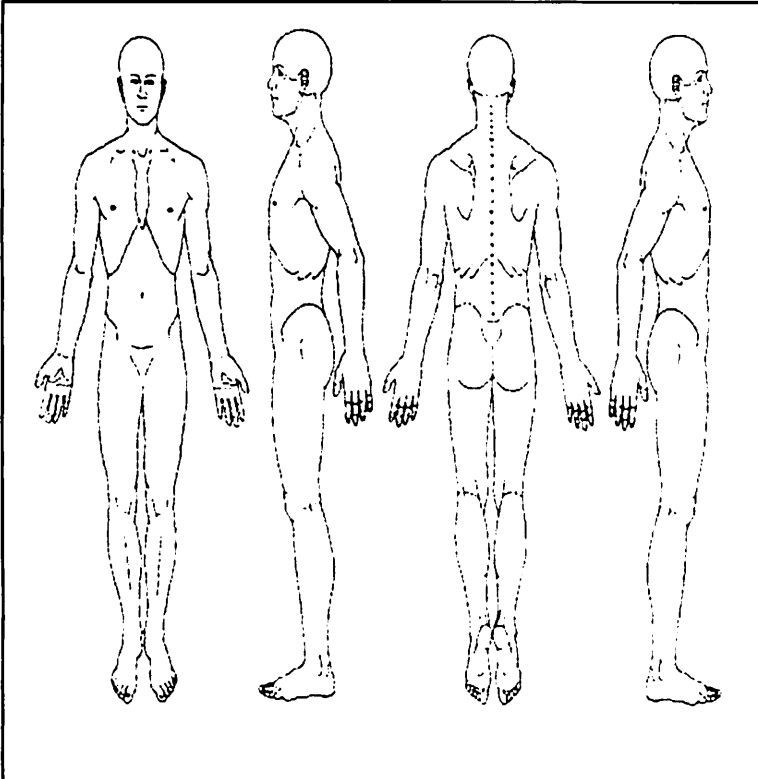
⇒ What did the hospital recommend?  No Instructions  See This Clinic  See DC  
 See Own Doctor  See Neurologist  See Orthopedist  
 Over The Counter Medication  Prescription Medication  
 Other: \_\_\_\_\_

⇒ Did you have any x-rays, CT Scans or MRI's taken?  Yes  No If yes, what areas? \_\_\_\_\_

31. How would you describe your current symptoms:  Pain  Numbness  Stiffness  Weakness

32. Describe the quality of your symptoms:  Burning Pain  Diffuse  Dull/Aching  Localized  
 Radiating  Sharp  Shooting  Stabbing  
 Throbbing  Tightness  Tingling  
 Other \_\_\_\_\_

33. Please mark the area of your symptoms:

	<p>34. On a scale of 0 to 10, zero being the lowest level and ten being the highest, how would you rate the effect your condition or pain has on your daily functioning when you are at rest? (Circle)</p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p>35. On the same scale of 0 to 10, zero being the lowest level and ten being the highest, how would you rate the effect your condition or pain has on your daily functioning when you are active? (Circle)</p> <p>0 1 2 3 4 5 6 7 8 9 10</p>
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36. When did this condition originally begin? \_\_\_\_\_

37. Is your condition currently...  Worsening  Improving  Unchanged ?

38. If you condition has worsened or is worsening, when did the increased symptoms start? \_\_\_\_\_

39. When was the last time you experienced these symptoms? \_\_\_\_\_

40. Is your condition is worse in the:  Morning  Afternoon  Night  With Activity  
and is it mostly:  Intermittent  Constant throughout the day.

41. Is your condition better in:  Warm Temp  Cold Temp  Neither

42. Is your condition worse in:  Warm Temp  Cold Temp  Damp  None

43. Check any of the following signs or symptoms that are associated with your current condition:

Headaches (Describe your headaches in detail): \_\_\_\_\_

- |  |                                     |  |  |  |
|--|-------------------------------------|--|--|--|
| <input type="checkbox"/> Blurred Vision  | <input type="checkbox"/> Depression | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Irritability / Mood Swing |  |
| <input type="checkbox"/> Ringing in the ears   | <input type="checkbox"/> Fainting   | <input type="checkbox"/> Confusion       | <input type="checkbox"/> Loss of Concentration     | <input type="checkbox"/> Loss of Smell     |
| <input type="checkbox"/> Localized Tingling  | <input type="checkbox"/> Nausea     | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Stiffness                 | <input type="checkbox"/> Problems Sleeping |
| <input type="checkbox"/> Radiating Pain/Sensation (Describe the location and type of sensation): _____ |                                     |  |  |  |

Weakness (Describe the location): \_\_\_\_\_

- |   |                                    |   |                                     |                                       |
|---|------------------------------------|---|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aches                              | <input type="checkbox"/> Cold Limb | <input type="checkbox"/> Dizziness      | <input type="checkbox"/> Ecchymosis | <input type="checkbox"/> Fatigue      |
| <input type="checkbox"/> Fever                              | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Muscle Spasm   | <input type="checkbox"/> Nausea     | <input type="checkbox"/> Numbness     |
| <input type="checkbox"/> Pale Bluish Skin                   | <input type="checkbox"/> Panic     | <input type="checkbox"/> Pins & Needles | <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Short Breath |
| <input type="checkbox"/> Stiffness                          | <input type="checkbox"/> Sweating  | <input type="checkbox"/> Swelling       | <input type="checkbox"/> Tingling   | <input type="checkbox"/> Vomiting     |
| <input type="checkbox"/> Other not Listed (Describe): _____ |                                    |   |                                     |                                       |

44. Do your symptoms seem to be better with:

<input type="checkbox"/> Nothing	<input type="checkbox"/> Activity	<input type="checkbox"/> Bending	<input type="checkbox"/> Cold	
<input type="checkbox"/> Heat	<input type="checkbox"/> Massage	<input type="checkbox"/> Movement		
<input type="checkbox"/> Over-The-Counter Medications	<input type="checkbox"/> Prescription Medications	<input type="checkbox"/> Rest		
<input type="checkbox"/> Stretching	<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Twisting	<input type="checkbox"/> Walking

### HEALTH HISTORY

This section will identify key factors and indicators about your history that may impact or contribute to your current health condition. Please give us information on any below that apply to you.

45. Please list any medications or nutritional supplements that you are currently taking: \_\_\_\_\_

46. Please list any other doctors or providers that you have seen for this condition or for any conditions that you may be currently treating and the type of treatments provided: \_\_\_\_\_

47. Childhood Illnesses (Please list any illnesses that you have had as a child): \_\_\_\_\_

48. Adult Illnesses (Please list any illnesses that you have had as a child): \_\_\_\_\_

49. Surgeries (Please list all surgical procedures that have had in the past): \_\_\_\_\_

50. Injuries (Please list any significant injuries, falls, trauma, accidents that you have had in the past): \_\_\_\_\_

51. Immunizations (Please list any vaccinations that you have had): \_\_\_\_\_

52. Non Drug Allergies and how you react to those substances: \_\_\_\_\_

### FAMILY HISTORY

This section will identify any possible genetic characteristics or risk factors that may impact or contribute to your current health

condition.

53. Please describe your family history:

General Family	Alive	Deceased	Health Conditions / Diseases / Conditions
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Paternal Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	_____
Paternal Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Maternal Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	_____
Maternal Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Son(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Daughter(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____

**SOCIAL & WORK HISTORY**

This section will identify key factors and indicators about your lifestyle that may impact or contribute to your current health condition. Please check as many as apply.

54. Please describe you alcohol use:  Social Consumption Only  Beer  Liquor  Wine

How much alcohol do you regularly drink? \_\_\_\_\_

55. Please describe your average diet:  High Fat  High Fiber  High Protein  High Salt  
 Low Calorie  Low Carbohydrate  Low Fat  Low Salt  Low Sugar

56. What is the highest education level you have attained? \_\_\_\_\_

57. Have you ever used illegal substances or IV drugs?  Yes  No

58. Please describe your tobacco use:  None  I live with a smoker  I smoked/chewed but quit  
 I currently smoke  I currently chew snuff

59. Please describe your condition's effect on your activities of daily living (ADL's):

Caring for Infirm Family:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (I can do it)	<input type="checkbox"/> Painful (I'm limited)	<input type="checkbox"/> Unable to Perform
Carrying Groceries:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (I can do it)	<input type="checkbox"/> Painful (I'm limited)	<input type="checkbox"/> Unable to Perform
Change Position (Sit to Stand):	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (I can do it)	<input type="checkbox"/> Painful (I'm limited)	<input type="checkbox"/> Unable to Perform
Climbing Stairs:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (I can do it)	<input type="checkbox"/> Painful (I'm limited)	<input type="checkbox"/> Unable to Perform
Daily Pet Care:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (I can do it)	<input type="checkbox"/> Painful (I'm limited)	<input type="checkbox"/> Unable to Perform
Driving:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (I can do it)	<input type="checkbox"/> Painful (I'm limited)	<input type="checkbox"/> Unable to Perform
Extended Computer Use:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (I can do it)	<input type="checkbox"/> Painful (I'm limited)	<input type="checkbox"/> Unable to Perform
Household Chores:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (I can do it)	<input type="checkbox"/> Painful (I'm limited)	<input type="checkbox"/> Unable to Perform
Lifting Children:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (I can do it)	<input type="checkbox"/> Painful (I'm limited)	<input type="checkbox"/> Unable to Perform
Self Care-Bathing:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (I can do it)	<input type="checkbox"/> Painful (I'm limited)	<input type="checkbox"/> Unable to Perform
Self Care-Dressing:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (I can do it)	<input type="checkbox"/> Painful (I'm limited)	<input type="checkbox"/> Unable to Perform
Self Care-Shaving:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (I can do it)	<input type="checkbox"/> Painful (I'm limited)	<input type="checkbox"/> Unable to Perform
Sexual Activities:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (I can do it)	<input type="checkbox"/> Painful (I'm limited)	<input type="checkbox"/> Unable to Perform
Sleeping:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (I can do it)	<input type="checkbox"/> Painful (I'm limited)	<input type="checkbox"/> Unable to Perform
Static Sitting:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (I can do it)	<input type="checkbox"/> Painful (I'm limited)	<input type="checkbox"/> Unable to Perform
Static Standing:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (I can do it)	<input type="checkbox"/> Painful (I'm limited)	<input type="checkbox"/> Unable to Perform
Walking:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (I can do it)	<input type="checkbox"/> Painful (I'm limited)	<input type="checkbox"/> Unable to Perform
Yard Work:	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (I can do it)	<input type="checkbox"/> Painful (I'm limited)	<input type="checkbox"/> Unable to Perform

60. Please list any recreational activities or hobbies and describe your condition's effect on those activities:

List: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (I can do it)	<input type="checkbox"/> Painful (I'm limited)	<input type="checkbox"/> Unable to Perform
List: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (I can do it)	<input type="checkbox"/> Painful (I'm limited)	<input type="checkbox"/> Unable to Perform
List: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (I can do it)	<input type="checkbox"/> Painful (I'm limited)	<input type="checkbox"/> Unable to Perform
List: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (I can do it)	<input type="checkbox"/> Painful (I'm limited)	<input type="checkbox"/> Unable to Perform

61. Please describe your current employment status:  Student (Part / Full Time)  Unemployed  Retired  Homemaker  Not Working (LOA)  Not Working (Summer Break)  Partially Disabled (%    )  100% Disabled  Disabled Veteran (%    )  100% Disabled Veteran  Currently Employed as a:

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62. How would you classify your job based on the following lifting limits?  
 Sedentary (Less than 5 lbs.)  Light (6 to 20 lbs.)  Moderate (21 to 49 lbs.)  
 Heavy (Greater than 50 lbs.)

63. How often do you lift at your job?  
 Constant (66 to 100% of the day)  Frequent (33 to 65% of the day)  Occasional (0 to 32% of the day)

64. Lifting Postures:  Sitting  Kneeling/Stooping  Arms Up  Shoulder  Standing  
 Abnormal Position  Abnormal Position

65. How many hours per day do you do each of the following activities?  
 Sitting:       Standing:       Walking:       Climbing:       Pushing:       
 Pulling:       Kneeling:       Reaching:       Twisting:     

66. If you lift at work, what type of lifting is most frequent?  Torso Level  Knee Level  Floor Level  
 Arm Level  Shoulder Level  High and Near  Off Posture / Off Balance  Standing & Twisting  
 Standing, Twisting & Bending  Sitting & Twisting  Sitting, Twisting & Bending  Other (Explain):

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67. Please describe your condition's effect on your job performance:  
 No Effect  Painful (I can do it)  Painful (Limited Ability)  Painful (Limited Duty)  
 Unable to Perform (No Limited Duty)  Unable to Perform (Can Not Do Limited Duty)

Is there any other information that you feel would be relevant to your current condition that was not covered?  
Please explain in the following section any information that you feel would be helpful to the doctor in reviewing your case.

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## Review of Systems

Patient Name: \_\_\_\_\_ Patient No. \_\_\_\_\_ Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**INSTRUCTIONS.** Below is a list of symptoms and diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care. Please fill out all of the sections. If none of the conditions apply to you, select "None."

### Constitutional:

- None
- Chills
- Daytime Somnolence  
(*drowsiness*)
- Fatigue
- Fever
- Night Sweats
- Weight Gain
- Weight Loss

### Eyes/Vision:

- None
- Blindness
- Blurred Vision
- Cataracts
- Change in vision
- Double Vision
- Eye Pain
- Field Cuts
- Glaucoma
- Itching (*around the eyes*)
- Photophobia
- Tearing
- Wears Glasses or Contacts

### Ears, Nose and Throat:

- None
- Bleeding
- Dental Implants
- Dentures
- Difficulty Swallowing
- Discharge
- Dizziness
- Ear Drainage
- Ear Infection(s)
- Ear Pain
- Fainting
- Headaches
- Head Injury (*history of*)
- Hearing Loss
- Hoarseness
- Loss of Smell
- Nasal Congestion
- Nose bleeds  
(*frequent*)
- Post Nasal Drip
- Rhinorrhea (*runny nose*)
- Sinus Infections
- Snoring
- Sore Throats
- Tinnitus (*ringing in the ears*)
- TMJ Disorder

### Respiration:

- None
- Asthma
- Coughing up  
blood
- Shortness of Breath
- Sputum Production
- Wheezing

### Cardiovascular:

- None
- Angina (*chest pain or discomfort*)
- Chest Pain
- Claudication (*leg pain or achiness*)
- Heart Murmur
- Heart Problems
- Orthopnea (*difficulty breathing while lying*)
- Palpitations (*irregular or forceful heart beat*)
- Paroxysmal Nocturnal  
Dyspnea (*shortness of breath at night*)
- Shortness of Breath
- Swelling of Leg(s)
- Ulcers
- Varicose Veins

### Gastrointestinal:

- None
- Abdominal Pain
- Belching
- Black, Tarry Stools
- Constipation
- Diarrhea
- Difficulty Swallowing
- Heartburn
- Hemorrhoids
- Indigestion
- Jaundice (*yellowing of the skin*)
- Nausea
- Rectal Bleeding
- Abnormal Stool Caliber  
(*quality*)
- Abnormal Stool Color
- Abnormal Stool  
Consistency
- Vomiting
- Vomiting Blood

### Female:

- None
- Birth Control Therapy
- Breast Lumps / Pain
- Burning Urination
- Cramps
- Frequent Urination
- Hormone Therapy
- Irregular Menstruation
- Urine Retention
- Vaginal Bleeding
- Vaginal Discharge

### Male:

- None
- Burning Urination
- Erectile Dysfunction
- Frequent Urination
- Hesitancy or Dribbling
- Prostate Problems
- Urine Retention

### Endocrine:

- None
- Cold Intolerance
- Diabetes
- Excessive Appetite
- Excessive Hunger
- Excessive Thirst
- Frequent Urination
- Goiter
- Hair Loss
- Heat Intolerance
- Unusual Hair Growth
- Voice Changes

### Skin:

- None
- Changes in Nail Texture
- Changes in Skin Color
- Hair Growth
- Hair Loss
- Hives
- Itching
- Paresthesia (numbness,  
prickling, or tingling)
- Rash
- History of Skin Disorders
- Skin Lesions or Ulcers
- Varicosities

### Nervous System:

- None
- Dizziness
- Facial Weakness
- Headaches
- Limb Weakness
- Loss of Consciousness
- Loss of Memory
- Numbness
- Seizures
- Sleep Disturbance
- Slurred Speech
- Stress
- Strokes
- Tremors
- Unsteadiness of Gait

### Psychological:

- None
- Anhedonia (*inability to experience joy or enjoy life*)
- Anxiety
- Appetite Changes
- Behavioral Change(s)
- Bipolar Disorder
- Confusion
- Convulsions
- Depression
- Insomnia
- Memory Loss
- Mood Change(s)

### Allergy:

- None
- Anaphylaxis (*history of*)
- Food Intolerance
- Itching
- Nasal Congestion
- Sneezing

### Hematology:

- None
- Anemia
- Bleeding
- Blood Clotting
- Blood Transfusion(s)
- Bruises easily
- Fatigue
- Lymph Node Swelling

## PATIENT AUTO/WORKER'S COMPENSATION INFORMATION SHEET

**INSTRUCTIONS:** The following information is needed upon your arrival here at On-Site Mobile Chiropractic. Please take this time to complete the appropriate information below as it relates to your injury. This information is used for billing purposes only. If you do not have this information available at this time, please let a staff member know. You will be required to have the information completed and returned upon your next visit.

Patient Name: \_\_\_\_\_

Date of Accident/Injury/Loss: \_\_\_\_\_

### AUTO ACCIDENT INSURANCE INFORMATION

If you have not completed an application of benefits from your auto carrier, you must do so for charges to be covered.

Auto Insurance Carrier: \_\_\_\_\_

Auto Insurance Carrier Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_

Insurance Carrier Address: \_\_\_\_\_

Claim Adjuster's Name:

Claim Number: \_\_\_\_\_

### WORKER'S COMPENSATION INFORMATION

An accident report must have been filed with your employer for charges to be covered and a workers compensation form must also be completed. If our clinic is not part of your employer's worker's compensation panel, you may be required to go to a panel provider for an initial visit before requesting transfer of your case to this office. If you are unsure if we are part of your employer's panel, please ask a member of our staff for assistance.

Employer: \_\_\_\_\_

Employer's Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Human Resource Manager's Name:

Claim Number: \_\_\_\_\_