JOB INJURY REPORT Today's date:_____

Additional information is needed for worker's compensation cases. Please answer all questions as accurately and completely as possible. Thank you.

Name:_____ Accident date:_____ Time:_____am - pm

Your employer:_____ Occupation:_____

Employer address:_____ Employer phone:_____

Accident reported to:_____ Title:_____ Date/Time reported:_____

Person authorizing treatment:_____ Title:_____

Have you seen a company doctor for this injury: ❒ Yes ❒ No Dr._____

Does your employer require you to see a company doctor first: ❒ Yes ❒ No ❒ Don't know

Who recommended care at this office:_____ Title:_____

Disposition: ❒ regular duty ❒ light duty ❒ off work ❒ temporary disability ❒ permanent disability

Dates of work missed:_____ Date you returned to work:_____ Your age:_____

Describe the accident in detail: _____

_____

After the accident, did you go: ❒ home ❒ ER via ambulance ❒ ER via own car ❒ ER via another person

❒ back to work ❒ to family doctor ❒ to chiropractor ❒ to company doctor ❒ _____

Doctor's name:_____ Type of Doctor:_____ Date:_____

Doctor's name:_____ Type of Doctor:_____ Date:_____

Treatment: ❒ x-rays ❒ medication ❒ physical therapy ❒ bed rest ❒ brace ❒ _____

What symptoms did you immediately feel: _____

What are your present complaints: _____❒ improving ❒ same ❒ worse

Severity of pain: ❒ mild ❒ moderate ❒ severe Describe pain:_____

Did you have *any* physical complaints before the accident: ❒Yes ❒No What:_____

Were these complaints the result of a previous accident: ❒Yes ❒No Date:_____

Describe details of previous accident:_____