

WORK RELATED INJURY FORM

Name: _____ Claim#: _____

Adjustor's Name and Phone#: _____

Date of Injury: _____ Time of Injury: _____

Was the injury reported to your Employer? Yes _____ No _____
(If no, please report it immediately)

Name of Employer: _____

Address and Phone # of Employer: _____

How did the injury occur? _____

How did you feel immediately after the injury? _____

Did you miss work for any period? _____ If yes, please give dates _____

Are you presently working at full duties, full time? Yes _____ No _____

If no, please give the last date of work or the current restrictions? _____

Who was the first to examine and treat you after the injury? (ie., first-aid, medical doctor, chiropractor, etc.) and when? _____

Are you currently receiving treatment? _____

Are there prior or other problems/conditions affecting this injury? Yes _____ No _____

If Yes, please give details? _____

***Patient assumes responsibility of payment until the account is paid in full by WCB, at which time the patient will be fully reimbursed**

Patient's Signature: _____ Date: _____



Guildford Chiropractic