DATE: _____

Seebacher Family Chiropractic Center
1385 Old Freeport Rd
Pittsburgh, PA 15238

PH: (412)449-1000
FAX: (412)449-0199

WORKER'S COMPENSATION HISTORY FORM

****IMPORTANT – PLEASE FILL OUT THE FOLLOWING QUESTIONS COMPLETELY AND IN DETAIL.**

NAME(Print):_____ **DOB:**_____

ADDRESS:_____ **PHONE #:** _____

_____

_____

EMPLOYER:_____**ADDRESS:**_____

HAVE YOU REPORTED YOUR INJURY TO YOUR EMPLOYER?_____

IS SEEBACHER FAMILY CHIROPRACTIC CENTER NAMED ON YOUR EMPLOYER'S LIST OF WORK COMP. DOCTORS? _____

DID YOU OBTAIN APPROVAL FROM YOUR EMPLOYER TO COME TO THIS OFFICE?_____

NAME OF WORK COMP. INSURANCE CARRIER_____

MEDICAL CLAIM NUMBER:_____**CLAIM ADJUSTOR:**_____

CLAIM ADJUSTOR PHONE NO:_____**ext.**_____

DATE OF ACCIDENT:_____**TIME OF ACCIDENT:**_____

WHERE DO YOU FEEL PAIN?_____

WHERE WERE YOU TAKEN AFTER THE ACCIDENT?_____

HAVE YOU MISSED ANY WORK BECAUSE OF THIS ACCIDENT?_____

WHEN DID YOU LAST WORK?_____

HAVE YOU RETURNED TO WORK?_____**DATE RETURNED?**_____

DID YOU CONSULT ANY OTHER DOCTOR? NAME?_____

If yes, WHAT TREATMENT/TESTS DID YOU RECEIVE?_____

HOW LONG DID YOU RECEIVE CARE FROM THE OTHER DOCTOR(S)?_____

HAVE YOU EVER INJURED THIS AREA BEFORE? WHEN? _____

IF INJURED BEFORE, HOW MUCH TIME LOST?_____

ANY SURGERIES? PLEASE EXPLAIN:_____

_____

HAVE YOU EVER HAD ANY COMPLAINTS IN THE AREA INVOLVED PRIOR TO THE PRESENT ACCIDENT?_____

DO YOU HAVE ANY OTHER DISEASE OR ACCIDENT THAT AFFECTS YOUR EMPLOYMENT?_____

IF YES, EXPLAIN:_____
_____
_____
_____

HISTORY OF ABSENTEEISM CAUSED FROM ACCIDENTS ON THE JOB:_____
_____
_____

BEFORE THE INJURY, WERE YOU CAPABLE OF WORKING ON AN EQUAL BASIS WITH OTHERS YOUR AGE?_____

WHAT IS THE LENGTH OF YOUR PRESENT OCCUPATION?_____
WHAT IS YOUR PRESENT OCCUPATION?_____

SINCE THE INJURY, ARE YOUR SYMPTOMS: _____**IMPROVING**
_____**WORSE**
_____**SAME**

PLEASE EXPLAIN IN DETAIL, HOW THE ACCIDENT HAPPENED:_____
_____
_____
_____
_____
_____
_____

VISUAL ANALOG SCALE

RATE THE PAIN THAT YOU ARE EXPERIENCING TODAY

0----------100
NO PAIN **SEVERE PAIN**

PATIENT SIGNATURE:_____ **DATE:** _____