

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

DATE: _____

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

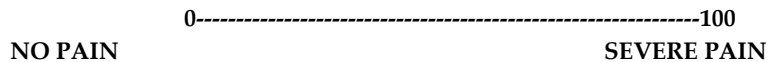
_____ WORSE

_____ SAME

PLEASE EXPLAIN IN DETAIL, HOW THE ACCIDENT HAPPENED: _____

VISUAL ANALOG SCALE

RATE THE PAIN THAT YOU ARE EXPERIENCING TODAY



PATIENT SIGNATURE: _____ DATE: _____