

No Fault Incident Report

Name _____ Date of Injury _____

Description of Complaint _____

Description of Accident/Injury _____

Have you missed work because of your injury? (list dates) _____

No Fault Insurance Information

Insurance Carrier _____ Phone # _____

Address _____

City _____ State _____ Zip Code _____

Case # _____

Adjuster _____ Adjuster Phone # _____

Treatment History

Have you been treated by another Dr? _____

If Yes, When/Where _____

Results of Treatment _____

Have you been treated by another Chiropractor? _____

If Yes, When/Where _____

Results of Treatment _____

Did you have any imaging or tests done as a result of this injury? _____

If Yes, When/Where _____

Evaluation Questions

Level of pain at time of injury: (circle) no pain=0—1—2—3—4—5—6—7—8—9—10=worst pain possible

Level of pain today: (circle) no pain=0—1—2—3—4—5—6—7—8—9—10=worst pain possible

Amount of time able to **work** prior to injury without increased pain _____

Amount of time able to **work** after your injury without increased pain _____

Amount of time able to **walk** prior to injury without increased pain _____

Amount of time able to **walk** after your injury without increased pain _____

Amount of time able to **sit** prior to injury without increased pain _____

Amount of time able to **sit** *after your injury* without increased pain_____

Amount of time able to **lift** *prior to injury* without increased pain_____

Amount of time able to **lift** *after your injury* without increased pain_____

Amount, in pounds, able to **lift** *prior to injury* without increased pain_____

Amount, in pounds, able to **lift** *after your injury* without increased pain_____

Amount of time able to **do chores** *prior to injury* without increased pain_____

Amount of time able to **do chores** *after your injury* without increased pain_____

Amount of time able to **sleep** *prior to injury* without increased pain_____

Amount of time able to **sleep** *after your injury* without increased pain_____

Amount of time able to **drive** *prior to injury* without increased pain_____

Amount of time able to **drive** *after your injury* without increased pain_____

Amount of time able to **groom** *prior to injury* without increased pain_____

Amount of time able to **groom** *after your injury* without increased pain_____

Please describe any other limitations or important information related to this injury_____

Printed Name_____

Signature_____

Date_____