Workers Compensation Incident Report

Name_____ Date of Injury_____

Description of Complaint_____

_____

Description of Accident/Injury_____

_____

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

Job duties on day of injury_____

Employer Information

Employer_____Phone #_____

Address_____

City_____ State_____ Zip Code_____

Workers Compensation 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_____