

SYLVAN CHIROPRACTIC CLINIC AND WELLNESS CENTER, LLC
5440 SW WESTGATE DR., SUITE 100 ♦ PORTLAND, OR. 97221 ♦ 503.297.4447 ♦ FAX: 503.296.8414

WORKERS' COMPENSATION PATIENT FORM

Please answer ALL the questions completely. All information provided is strictly confidential. If you do not understand a question or are unsure of the information, please ask for assistance.

Worker's Legal Name: _____ Date: _____
Worker's Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: ____/____/____ Age: _____ SS#: _____ - _____ - _____ Marital Status: M S W D
Primary Phone: _____ Date of Injury: ____/____/____ Time of Injury: ____/____/____
Emergency Contact: _____ Relation: _____
Address: _____ Phone: _____
Is your condition due to an injury/illness that occurred at your place of employment? Yes No
Have you lost any days from work? Yes No How many? _____ Date last worked? _____
Workers' Compensation Insurance Company: _____
Adjuster's Name: _____ Phone: _____
Policy #: _____ Claim #: _____

EMPLOYMENT INFORMATION

Occupation: _____ Employer at time of accident: _____
Employer Address: _____
City: _____ State: _____ Zip: _____ Employer Phone: _____
Describe your job: _____
What were you doing at the time you were injured? How did the accident/injury occur (lifting, bending, walking, carrying, standing, etc.)? _____

When did the pain begin? Where did you first feel it? Was the pain intense at first, or did you feel pain that gradually worsened? _____

Describe the physical conditions which may have contributed to your present injury: darkness, faulty equipment, slippery floor, limited space, etc. Distinguish natural hazards from hazards created by other employees. _____

Were you hospitalized as a result of this accident? Yes No
If yes, where? _____
How many doctors have you seen for this injury? _____
Please detail what treatments you received and from whom (drugs, adjustments, physiotherapy, exercises, braces, etc.):
Doctor #1: Name: _____ Date of first visit: ____/____/____
Were you examined? Yes No Were x-rays taken? Yes No What body parts? _____
What kind of treatment did you receive? _____

*****PLEASE CONTINUE TO OPPOSITE SIDE OF THIS FORM*****

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What benefits did you receive from the treatment? _____

_____ Date of last treatment: ____/____/____

Doctor #2: Name: _____ Date of first visit: ____/____/____
Were you examined? Yes No Were x-rays taken? Yes No What body parts? _____
What kind of treatment did you receive? _____
What benefits did you receive from the treatment? _____

_____ Date of last treatment: ____/____/____

Doctor #3: Name: _____ Date of first visit: ____/____/____
Were you examined? Yes No Were x-rays taken? Yes No What body parts? _____
What kind of treatment did you receive? _____
What benefits did you receive from the treatment? _____

_____ Date of last treatment: ____/____/____

What date did you report this accident? ____/____/____
To whom did you report this accident? _____ What is their position? _____
Was there a witness to your accident? Yes No
If yes, what was their name? _____ What is their position? _____
Have you ever had any prior injuries, accidents, diseases, or treatment to the area of your body now affected? Yes No
If yes, state what part of your body was previously injured: _____
Date of injury: ____/____/____ Describe the accident: _____
Who treated you? _____
What date did the treatment begin? ____/____/____ and end? ____/____/____
When was the last time you felt pain or had problems resulting from that injury? _____
Have you lost any time from work as a result of this new injury? Yes No
If yes, please give dates: ____/____/____, ____/____/____, ____/____/____, ____/____/____
If you are currently on disability (time loss) do you want to go back to work doing your regular work duties? Yes No
If no, please state why: _____
Have you gone back to work? Yes No
If yes, when? ____/____/____ What status of work? Modified Regular
If modified, please list what restrictions you have been placed on: _____

Thank you for completing this questionnaire and intake form regarding your recent accident and injury.
The information provided will help us create the most effective treatment for your rapid improvement.