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:** _____ □AM □PM
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.