KARE
CHIROPRACTIC
"Because We Care About Your Health"

Worker's Compensation Questionnaire

Date of Accident: _____ Have you reported it? ☐ Yes ☐ No

Date of Hire: _____ Job Title/Position: _____

Name of Employer: _____

Supervisor's Name: _____ Supervisor's Phone Number: _____

Employer Address: _____

Is your employer aware you are seeking medical treatment today? ☐ Yes ☐ No

If no, please explain: _____

Body parts injured (i.e. low back, right shoulder: _____

Please describe how the injury occurred in detail: _____

_____

_____

Current working status: ☐ Working full duty ☐ Modified/light duty ☐ Off work ☐ Terminated ☐ On leave

Are you currently under work restrictions? ☐ Yes ☐ No ☐ Unknown

If yes, please describe: _____

Was any third party (not your employer or coworker) involved in this injury? ☐ Yes ☐ No

If yes, explain: _____

Insurance Company: _____

Claim #: _____ Phone #: _____

Adjuster: _____ Ext/Direct: _____

Adjuster email: _____

Attorney Name(*if applicable*): _____ Attorney Phone #: _____

Attorney Email: _____

Patient Name(Print): _____

Patient Signature(X): _____ **Date:** _____