CenterPoint Chiropractic
Work Related Accident Form

Patient's Name: ____ Today's Date: ___________

Date of Accident: _______________ Time of Accident: _________ ▫ a.m. ▫ p.m.

Was your accident directly related to your work? ▫ Yes ▫ No

Briefly describe the events that occurred just before and during your accident:

____

____

____

Give the address where the accident occurred: (if other than the employer's address)

____

Was anyone else present during your accident? ▫ Yes ▫ No

Did you report your accident to your employer? ▫ Yes ▫ No

What recommendations did your employer make just after your accident?

____

____

Has this type of accident happened to you before? ▫ Yes ▫ No

To the best of your knowledge, has this accident occurred in your workplace before? ▫ Yes ▫ No

In general:

Is your job physically stressful? ▫ Yes ▫ No

Is your job mentally stressful? ▫ Yes ▫ No

Is your workplace noisy? ▫ Yes ▫ No

Have you changed jobs in the last year? ▫ Yes ▫ No

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 90 days, or if you suspend or terminate care, any fees and services are due immediately.

Print Patient Name ____ Date: __________________________

Patient/Responsible Party Signature ____