1305 Grandview Ave
Pittsburgh, PA 15211
Phone: 412-381-9977
Fax: 412-381-1215

WORKERS COMPENSATION

First Name: ______________________ Last Name: ______________________ Middle Initial: ______

Date of Birth: ___/___/______ SS#: ____________________ Sex: ☐ Male ☐ Female ☐ Other

Address: ____

City: ___________________________ State: _______________ Zip Code: __________________

Home Phone: (______) _______- __________ Cell Phone: (______) _______-___________

Employer Data

Employment Status: ☐ Employed Full-Time ☐ Employed Part-Time ☐ Unemployed

Employer's Name: ____ Phone #: (_____)__________

Type of Business: ________________________ Your Occupation: ____________________________

Employer Address: ____

City: ___________________________ State: _______________ Zip Code: __________________

Employer Insurance Information

Name of Employer Ins. Company: _________________________________ Phone #: (____)__________

Ins. Company Address: ____

City: ___________________________ State: _______________ Zip Code: __________________

Nature Of Injury

1. Date of Injury: ______/_____/______ Time of Day: ______________________
2. Accident reported to employer? ☐ **Yes** ☐ **No**
3. Are you currently off work?: ☐ **Yes** ☐ **No** Last Date Worked:_____/______/_________
4. If you are working, are you: ☐ Full-Time ☐ Part-Time ☐ Light Duty Duration:________________
5. Length of time worked there prior to accident: ____
6. Type of work being done at time of injury: ____

   ____

7. In your own words, please describe the accident: ________________________________

____

____

____

8. Since this injury occurred, are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same

9. Have you been treated by another doctor for this injury? ☐ **Yes** ☐ **No** If yes, please fill out the info below.

   Doctor's Name: ________________________________

   What type of treatment did you receive? ________________________________

   ____

   How long were you treated by this doctor? ________________________________

10. Please list any medications you were prescribed: ________________________________

    ____

    ____

    Do these medications help? ☐ **Yes** ☐ **No** ☐ **Don't Know**

11. Have you been to physical therapy for this injury? ☐ **Yes** ☐ **No** If yes, how often?

    ☐ Daily ☐ Every other day ☐ Several times a week ☐ Weekly ☐ Every other week ☐ Monthly ☐ Other ________________________________ Does physical therapy help? ☐ **Yes** ☐ **No** ☐ **Don't Know**

12. Prior to this injury, did you have any physical complaints similar to what you have now? ☐ **Yes** ☐ **No** If yes, please describe: ________________________________

    ____

    ____

13. Have you had any prior surgeries? ☐ **Yes** ☐ **No**
    If yes, list type of surgery and date: ________________________________

    ____

    ____

14. Please describe the job duties you perform in a typical workday: ________________________________

    ____

    ____

    ____

    ____

15. Please describe how these job duties were affected by this injury: ________________________________

    ____

    ____

    ____

    ____

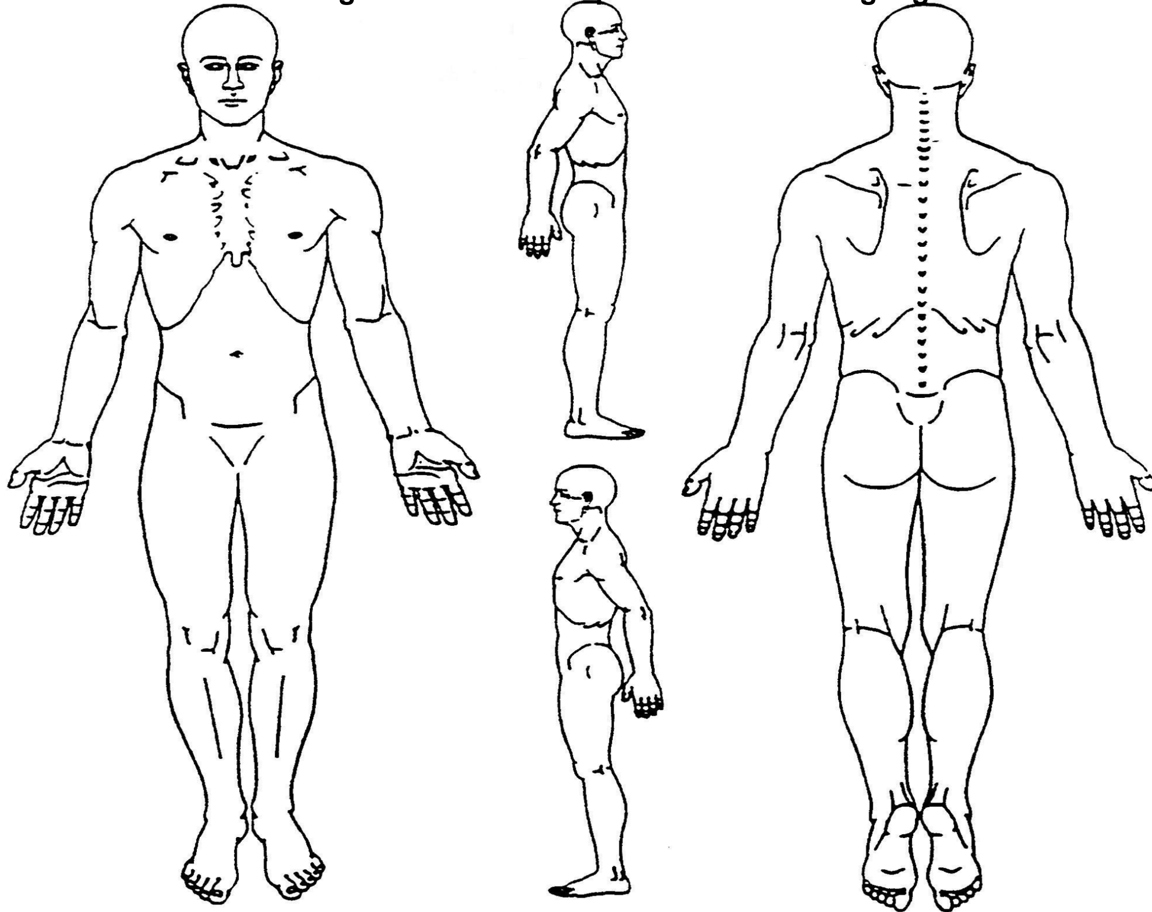
16. Please list any other comments: ________________________________

    ____

    ____

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N = Numbness **B = Burning** **S = Sharp** **T = Tingling** **A = Dull Ache**



Average pain intensity:

Last 24 Hours:	No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain
Past Week:	No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain

Does anything improve your pain? ☐Yes ☐No

If Yes, please list: ______________________________

When did your symptoms begin? ☐Day of Accident ☐Day After Accident ☐A Few Days After Accident ☐ A Week After Accident ☐Other ______________________________

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

☐Sharp ☐Ache ☐Numb ☐Shooting ☐Burning ☐Tingling ☐Throbbing ☐Other______________

Patient Signature: ______________________________ Date: ______________

Doctor Signature: ______________________________ Date: ______________

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, to whom I am legally responsible) by the doctor or chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other offices or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for a short period of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payments for treatments are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to self-administered, over the counter analgesics and rest, medical care with prescription drugs such as anti-inflammatory, muscle relaxants and painkillers, physical therapy,steroid injections, bracing and surgery. I understand and have been informed that I have the right to a second opinion and secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contect, and by signing below I agree to the above-named procedures. I intend this content to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient Signature: ____ Date: ___________________

Doctor Signature: ____ Date: ___________________