Chinese Acupuncture & Herb Center

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WORK INJURY INFORMATION

Today's Date:_____Patient Name: _____

Date of Accident: _____ Employer: _____
Employer Phone: _____ Employer Address: _____
Employer Fax: _____ Your Occupation:_____

Date Injured: _____/_____/_____ Time: _____AM/PM Last Date Worked: _____
Are you presently off Work? Yes / No
Has the injury been reported to your Employer? Yes/ No
Name of person injury was reported to:_____
Claim #:_____Insurance Company:_____
Claim Adjuster: _____Phone #:_____
Where Injured: _____City: _____State: _____Zip:_____

Length of Time you worked there prior to the injury: _____
Type of work being done at time of injury: _____
Describe the injury: _____
_____

Been evaluated or treated by another doctor in relation to this injury? Yes/ No
If yes, Name of doctor and address:_____

What type of treatment did you receive?_____
What medications are you taking?_____

Prior to this accident, have you ever had any physical complaints similar to what you have now?
If yes, please describe: _____
_____
Were any of these complaints the result of a previous accident or injury?
If yes, please describe: _____
_____

Have you contacted an Attorney? Yes/ No
Attorney's name?_____Phone #_____
Address: _____

_____ _____
Patient's or Patient's Guardian's Name Patient's or Patient's Guardian's Name Signature

_____
Date