Saleeby Chiropractic Centre, P.A.

Stephen M. Saleeby, D.C.
Wayne J. Prickett, D.C.

Work Related Accident/ Worker's Compensation

Today's Date: ____/____/____ Z #: _____

**** If you were injured on the job, you must REPORT THE INJURY to your employer. Failure to do so will result in denial of any payment. In the event that your worker's compensation insurance will not cover, you are responsible for your bill. Thank You.****

Name: _____ Age: _____ DOB: ____/____/____

Address: _____
City State Zip

SS#: _____ Driver's License#: _____

Phone#: _____ _____ _____
Home Cell Work

Date of Injury: ____/____/____ Time of Injury: _____ am/pm

Employer's Name: _____

Employer's Address: _____

Employer's Phone#: _____

Name of Supervisor/ Contact Person: _____

Have you retained legal council for this injury? ☐yes ☐no
If *yes* give name, address, phone number:
Name: _____
Address: _____
Phone: _____

Please explain how the accident happened: _____
_____
_____
_____
_____

Were there any witnesses to the accident? ☐yes ☐no

Who reported the accident? Name: _____ Title: _____

What medical attention was rendered? _____

3814 Browning Place, Suite102, Raleigh NC 27609
(919)782-4733 Fax (919)783-8225

_____

Where you treated at a medical facility following the accident? ☐yes ☐no
If *yes,* please explain: _____
_____
Was medication prescribed? ☐ yes ☐ no If *yes,* what? _____
Were X-rays taken? ☐ yes ☐no

Chief Complaint: _____

Symptoms:
_____

_____

Did you feel pain immediately at the time of injury? ☐yes ☐ no
If *yes,* where? _____

If *no*, please state when you began to have pain and where: _____

_____

Since the injury, are your symptoms: ☐improving ☐ the same ☐getting worse?

Did you return to work following the injury? ☐Yes ☐no
How much time have you lost from work as a result of this injury?
☐Hours ☐Days ☐Weeks ☐Months

When you reported the injury to your supervisor, were you instructed to see a particular doctor? ☐yes ☐ no
If *yes*, whom did you see? _____

Have you ever been injured before? ☐ yes ☐no If *yes*, please explain when, where, and how?
_____
_____

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

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal work day? _____
Please indicate you daily job duties and any activities which you are occasionally ask to do:
(*check all that apply*)

☐Standing ☐Driving ☐Sitting ☐Twisting ☐Walking

☐Stooping ☐Bending ☐Typing ☐Operating equipment

☐Lifting ☐Crawling ☐Work with arms above head

☐Other: _____

What positions can you work in with minimum physical effort and for how long? _____

_____

Prior to the injury were you capable of working on an equal basis with others your age?
☐yes ☐no ☐N/A

Do you work with other who can help you with heavy lifting? ☐yes ☐no ☐N/A

While in recovery, is there any light duty work you could request? ☐yes ☐no ☐N/A

****

Saleeby Chiropractic Centre, P.A. will file my worker's compensation claim on my behalf as a courtesy. If any medical or account information changes, I will immediately inform a staff member. In the event that I fail to prosecute the claim for worker's compensation claim, I hereby agree to pay for the balance of my account for any professional services rendered at Saleeby Chiropractic Centre, P.A.

Signature: _____

Printed Name: _____

Date: _____/_____/_____