PRAIRIE FAMILY & SPORTS CHIROPRACTIC
WORKERS COMPENSATION ACCIDENT REPORT

Today's date: ___/___/___

Name: _____

Employer's name: _____Phone #: _____

Employer's address: _____

Date of accident: ___/___/___ Time of accident: _____am/pm

Name of person the injury was reported to:_____ Date: ___/___/___

Where did the accident occur? _____

How did the accident happen? _____

_____

What did you feel immediately after the accident? _____

_____

What are your present complaints? _____

_____

When did your problems first start? _____

Were you taken anywhere after the accident? ☐YES ☐NO If yes, where: _____

What was done for you? _____

Have you seen any other doctors for this condition? ☐YES ☐NO Doctor's name: _____
Address: _____Phone #: _____

Have you missed any work due to this accident? ☐YES ☐NO If yes, Please describe: _____

_____

What type of work do you do? _____

Describe your daily job requirements (i.e. how much standing, sitting, lifting, # of pounds, repetitive movement, twisting, bending, stooping, etc.) _____

_____

_____

Has work aggravated your condition? ☐YES ☐NO If yes, describe: _____

_____

Are you presently unable to do / perform any social / recreational activities? ☐YES ☐NO If yes, please explain: _____