Dakota Chiropractic
making your health a priority

INTERNAL USE ONLY
___CASE TYPE ___COVERAGE TYPE
___CONDITION TAB ___CLAIM#
___BATCH CLAIM ONLY ___TERM OTHER COVERAGE

WORKERS COMPENSATION INTAKE FORM

1 ACCIDENT INFORMATION

FIRST NAME _____ LAST NAME _____

DATE OF INJURY _____ TIME _____ ◯ AM ◯ PM LOCATION _____

Please describe the circumstances of the accident in detail:

_____

_____

Where did you feel pain immediately after the accident? _____

Did you return to work? ◯ YES ◯ NO **If so, date returned:** _____

Did you consult any other doctors? ◯ YES ◯ NO **Doctor's Name:** _____

Diagnosis | Treatment _____

Have you ever injured this area before? ◯ YES ◯ NO **If yes, when?** _____

Did you lose time from work? ◯ YES ◯ NO **Doctor(s) consulted:** _____

Do any other diseases/accidents affect your employment? ◯ YES ◯ NO

If yes, explain: _____

At work do you favor any part of your body? ◯ YES ◯ NO If yes, explain: _____

Do you have a history of absenteeism caused from accidents on the job? ◯ YES ◯ NO

Have you ever had a Workers Compensation claim before? ◯ YES ◯ NO

Before the injury, were you capable of working on an equal basis with others your age? ◯ YES ◯ NO

Are your work activities restricted as a result of this accident? ◯ YES ◯ NO

Since this injury are your symptoms: ◯ IMPROVING ◯ GETTING WORSE ◯ STAYING THE SAME

2 EMPLOYMENT INFO

EMPLOYER/OCCUPATION _____ HR CONTACT _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____

3 INSURANCE INFORMATION

WORKERS COMPENSATION COMPANY _____ CASE WORKER'S NAME _____

ADDRESS _____

CLAIM# _____ PHONE _____

Do you have an attorney that has advised you in this case? ◯ YES ◯ NO

If yes, attorney's name & address _____

Dakota Chiropractic has my permission to share information with appropriate parties in order to process claims.

PATIENT NAME (PRINT) _____ PATIENT SIGNATURE _____ DATE _____