

KENWOOD CHIROPRACTIC ARTS

APPLICATION FOR TREATMENT (Confidential)

Date: _____ Social Security No.: _____

Name: _____ Age: _____ Birthdate: _____

Home Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Cellular/Pager: _____

E-mail: _____ Occupation: _____ Text o.k. Y or N

Employer's Name and Address: _____

Name of spouse or significant other: _____

Place of Employment: _____ Phone: _____

Who may we thank for referring you to us? _____ Phone: _____

Who may we contact in case of emergency? _____ Phone: _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Nearest relative not living with you: _____ Phone: _____

Nearest friend not living with you: _____ Phone: _____

I have read and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Date: _____

Patient Signature

Date: _____

Parent or Guardian (if minor)

Social Security Number

Internal Administrative Document

WORKER'S COMPENSATION QUESTIONNAIRE

Please answer all questions completely

Name _____ Date of Injury _____

Occupation _____ Who referred you to our office? _____

Phone # _____ Company Name _____ Address _____

Workers' Compensation Insurance Carrier:

Name _____ Address _____ Ph _____

DATE OF INJURY _____ Hour _____ AM PM

Please explain in DETAIL how your accident happened _____

Did you report the injury to your employer? Yes No

Where did you feel pain immediately after the accident? _____

Did you return to work Yes No If so, date returned to work _____

Did you consult any other doctor? Yes No

If so, give Doctor/s name _____ D.C. M.D. D.O. D.D.S

Have you ever injured this area before? Yes No If so, when? _____

If injured before, did you lose time from work? Yes No

If you lost time from work with injuries prior to this injury, give name of doctor/s consulted _____

Do any other diseases or accidents currently affect your employment? Yes No
If so, explain _____

In your work, do you have to favor any part of your body? Yes No
If so, explain _____

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? The same?

Have you retained an attorney? Yes No

If so, name, address and phone of attorney _____

_____ Date

_____ Patient Signature