Hoffmann Chiropractic
310 Maple Ave L 04
Barrington RI 02806
401-289-2444

WORKER'S COMPENSATION HISTORY

Patient ____ Date _______________
Sex _____ Marital Status________ Date of Birth_________ Home Phone # ________________
Address_______________________________ City______________ State____ Zip_____________
Occupation ____
Type of work you do (labor)____
Who referred you to our office? ____
Social Sec. # ________________ Business Ph #. ______________Company Name ____________________
Company Address ____
Please explain in detail how your injury occurred?____
____
____
____
____
Give time and date present injury occurred ______ ☐ AM ☐ PM ____/____/_______
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
Did your employer send you to a Doctor? ☐ Yes ☐ No
I so, give Doctor's name _____________________________ ☐ DC ☐ MD ☐ DO
Doctor's Diagnosis ____
Have you ever injured this area before? ☐ Yes ☐ No If so when ________________________________
Did you lose time from work? ☐ Yes ☐ No If so, how long ___________________________________
What medications are you presently taking? ____
____
Do any other diseases or accidents affect your employment? ☐ Yes ☐ No If so, explain___________
____
In you work, do you have to favor any part of your body? ☐ Yes ☐ No If so, explain_______________
____
Have you ever had a Worker's 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 the injury, are your symptoms ☐ Improving? ☐ Getting worse? ☐ The same?
Have you lost any time from work because of this accident? ☐ Yes ☐ No
If yes, give dates of time lost: From_________________ to ________________
Totally out of work from___________to_________Partially disabled_________ to ____________
Decreased hours or light duty from ___________ to ___________
Have you retained an attorney? ☐ Yes ☐ No Litigation? ☐ Yes ☐ No
Is so, name, address & phone # ____

Patient Signature:________________________________ Date:________________

Physician Signature:______________________________ Date:________________