ORTHOKANSAS, LLC

Work Related Injury/Liability Claim Information

Patient Name:_____ DOB:_____

Date /Time of Accident:_____

Employer at time of injury:_____

Occupation/Job Title:_____

Claim#:_____

Work Comp Insurance Carrier:_____

Adjuster Name:_____

Phone#:_____ Fax#:_____

Did you report your injury? ☐ YES ☐ NO If YES, to whom?

_____

Was a Workman's Compensation report filed? ☐ YES ☐ NO

Did you experience immediate pain? ☐ YES ☐ NO If no, when did pain occur?

_____

Please check affected areas: ☐ Head ☐ Neck ☐ Upper Back ☐ Lower Back

Arm ☐ LT ☐ RT Leg ☐ LT ☐ RT

Were you seen at a hospital after the accident? ☐ YES ☐ NO

If yes, please give name and address:_____

Were X-rays taken? ☐ YES ☐ NO What views were taken?_____

Have you missed work? ☐ YES ☐ NO

Are you presently off work? ☐ YES ☐ NO

If YES to either, who authorized time off and list dates:_____

_____

_____

Job Title and Brief Description of Duties:_____

_____

_____

_____

PLEASE COMPLETE SIDE 2 IN FULL

Please list all treatments (including dates) related to this injury with Medical Doctor, Chiropractor, Physical Therapy and diagnostic tests:

1._____

2._____

3._____

4._____

5._____

Any past history of problems involving affected area(s)? ☐ YES ☐ NO

If YES, please explain:_____

_____

_____

Please list insurance companies involved:_____

_____

Any problems with insurance company(s) paying medical bills or lost wages? ☐ YES ☐ NO

If YES, please explain:_____

_____

_____

Do you have an attorney or is there litigation pending? ☐ YES ☐ NO

If YES, please explain:_____

_____

_____

Please list any other pertinent information or comments which may assist in your treatment:

Signature:_____ **Date:_____**