Alpine Chiropractic Center

833 W Commercial Dr.
Wasilla, AK 99654
(907)376-2475

WORKER'S COMPENSATION HISTORY

Patient Name____**Age** _________
Birthdate ________________ **Sex**_________ **SS#**_________________________________
Employer's Name ____
Employer's Address ____
Insurance Co.____**Phone#**_____________________________
Agent ______________________________________**Claim#** ____________________________________
Address_______________________________________**City**_______________**State**______**Zip**_________

1. **Date Injured** _______________ **Hour**_______**AM / PM Last Date worked**___________________
2. **Accident reported to employer? ( ) Yes ( ) No**
3. **In your own words, please describe the accident:**____
____
____
____
4. **Did the accident render you unconscious?** __________ **If yes, for how long?** _______________
5. **Have you been treated by another doctor for this accident? ( ) Yes ( ) No**
If yes, please list doctor's name and address:____
____
What type of treatment did you receive? ____
Were X-rays taken? ____
6. **What types of medicines are you taking?** ____
____
7. **Indicate the symptoms that are a result of this accident:**__________________________________
____
____
____
8. **Are you: ( ) Improved ( ) Unchanged ( ) Getting worse**
9. **Are your work activities restricted as a result of this injury? ( ) Yes ( ) No**
10. **Prior to this accident, have you ever had any of the physical complaints similar to what you have now? ( ) Yes ( ) No ( ) Don't Know If yes, describe:**_______________________
____
____

Signature ____ **Date:**_______________________