



# FRANCIS CHIROPRACTIC

CLINIC AND WELLNESS CENTER

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DATE \_\_\_\_\_

WORKMAN'S COMPENSATION INJURY

NAME \_\_\_\_\_ AGE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_

DATE OF ACCIDENT \_\_\_\_\_ TIME \_\_\_\_\_ AM \_\_\_\_\_ PM

LOCATION OF ACCIDENT \_\_\_\_\_

PLEASE DESCRIBE ACCIDENT \_\_\_\_\_

HAVE YOU SEEN ANOTHER DOCTOR FOR THIS INJURY BEFORE COMING TO THIS OFFICE? [ ] YES [ ] NO

DID YOU RECEIVE TREATMENT: [ ] YES [ ] NO IF SO DESCRIBE \_\_\_\_\_

WERE YOU HOSPITALIZED? \_\_\_\_\_ HOW LONG? \_\_\_\_\_

LIST THE EXTENT OF INJURIES AS YOU KNOW THEM \_\_\_\_\_

DESCRIBE LOCATION AND CHARACTER OF JOB \_\_\_\_\_

DESCRIBE PHYSICAL ACTIVITY OF JOB \_\_\_\_\_

HOW MUCH DO YOU LIPT? \_\_\_\_\_ HOW OPTEN? \_\_\_\_\_

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THIS ACCIDENT:

- |                  |                              |                            |
|------------------|------------------------------|----------------------------|
| 1 ( ) HEADACHE   | 6 ( ) DIZZINESS              | 11 ( ) SHORTNESS OF BREATH |
| 2 ( ) NECK PAIN  | 7 ( ) PINS & NEEDLES IN ARMS | 12 ( ) LOSS OF MEMORY      |
| 3 ( ) NECK STIFF | 8 ( ) PINS & NEEDLES IN LEGS | 13 ( ) EARS RING           |
| 4 ( ) BACK PAIN  | 9 ( ) NUMBNESS IN FINGERS    | 14 ( ) LOSS OF BALANCE     |
| 5 ( ) CHEST PAIN | 10 ( ) NUMBNESS IN TOES      | 15 ( ) STOMACH UPSET       |
| ( ) OTHER _____  |                              |                            |

DID YOU REPORT THIS INJURY TO YOUR EMPLOYER? \_\_\_\_\_

DATE REPORTED \_\_\_\_\_ TO WHOM REPORTED \_\_\_\_\_

DID THEY GIVE AUTHORIZATION FOR TREATMENT? \_\_\_\_\_