Family Chiropractic
Ron Wilcox, D.C.

Worker Compensation

204 Pinehurst Dr. SW, Ste. 103, Tumwater, WA 98501
Tel: (360) 352-8112 • Fax: (360) 352-8113

Patient Name: ____ D.O.B.: _____/_____/__________

Employer: ______________________ Phone Number: __________________ Position: ________________

Supervisor Name and Title: _________________________________ Sup. Phone: ____________________

Date of Injury: _____/_____/__________ Decribe how you were injured: ____________________________

____

Describe Current Sympstoms: ____

Please list in order with the most painful condition first:

1. ____ 2.____

3. ____ 4.____

Described tasks effected by this injury: ____

Have you performed Lighy Duty work: □Yes □No If Yes, How long: _________________________________

Are you currently employed by the listed employer? □Yes □No

- *If No, please list current employer:* __________________________________

Have you seen another provider for this injury? □Yes □No *If Yes, please complete the following*:

- When: _____/_____/__________ Name of Provider/Facility: ___________________________________
- Diagnostics Performed: X-rays: □Yes □No MRI: □Yes □No If yes, Where:________________________
- Treament Rendered: Medications: □Yes □No If Yes, list:____________________________________

  Massage Therapy: □Yes □No Spinal Manipulation: □Yes □No Physical Therapy: □Yes □No

  If yes, list provider(s): ____

- What percentage of improvement have you achieved as of today? ______%

On the pictures below, use the key on the left to shade in the areas where you are currently experiencing discomfort:

Key:
Numbness
- - - - - - -

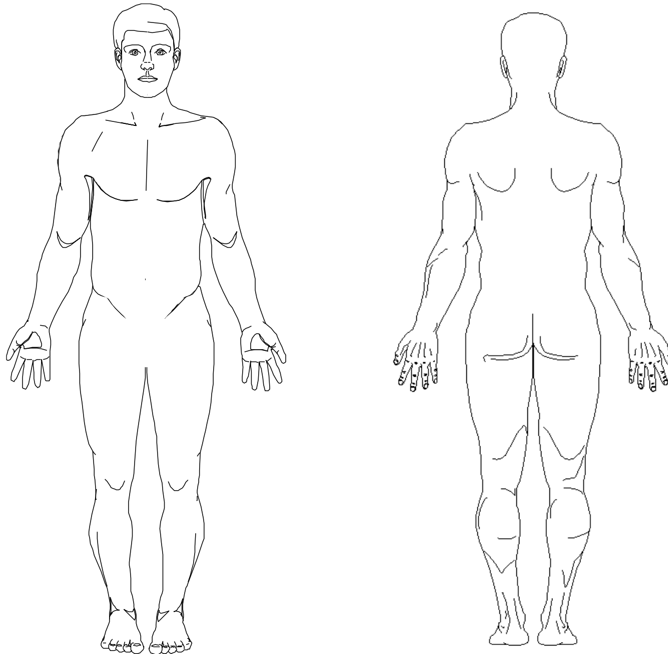
Pins and Needles
oooooooo

Burning
xxxxxxxx

Stabbing/Sharp
///////////////

Aching/Dull
****

Popping/Clicking
P P P



RCW 51.36.060 Provides: All medical information in the possession or control of any person and relevant to the particular injury in the opinion of he department pertaining to any worker whose injury or occupational disease is the basis of a claim under this title shall be made available at any stage of the proceedings to the employer, the claimant's representative, and the department upon request, and no person shal incur any legal liability by reason of relating such information.

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Patient/Legal Representative Signature Date

For Office Use Only

□L&I: Claim #: _______________ □Self Insured: Claim #: _________________ Payer: _________________

Claim Manager:____ Supervisor name: _________________Title: ______________

Tel.#: ______________________ Fax#:______________________ Tel# ____________________ Fax# _____________________