Ridge Chiropractic Center
104 Ridge Rd., Suite 144, Minooka, IL 60447

Darren Cissell, D.C.
Phone: 815-467-1464 Fax: 815-521-0492

WORKERS COMPENSATION FORM

Patient Name _____ Today's Date _____

EMPLOYER

Employer Name _____ Employer Phone # _____

Employer Address _____ City _____ State _____ Zip _____

Contact Person _____ Email Address _____

WORKERS COMPENSATION CARRIER

Workers Compensation Carrier _____ Adjuster's Name _____

Carrier Address _____ City _____ State _____ Zip _____

Carrier Phone # _____ **Claim #** _____

ATTORNEY INFORMATION (If applicable)

Attorney Name _____ Attorney Phone # _____ **File #** _____

Attorney Address _____ City _____ State _____ Zip _____

MECHANISM OF INJURY

Date of Injury _____/_____/_____ Hour of Accident _____ ☐ AM ☐ PM Place of Injury _____

Was the accident reported to your employer? ☐ No ☐ Yes Name of the person you reported to _____

Please fully describe how the accident happened _____

_____

Have you lost time from work because of this accident? ☐ No ☐ Yes If yes, how much time? _____

Other doctors seen for this condition (Doctor's name) _____

What diagnosis were you given? _____

What treatment was given? (Check all that apply) ☐ None ☐ X-rays ☐ Pain Medication ☐ Stitches ☐ Muscle Relaxants ☐ Bandaged

☐ Cervical Collar ☐ Physical Therapy ☐ Instructed Regarding Concussion ☐ Instructed Regarding Sprains & Strains

☐ Instructed to Call an Orthopedist ☐ Instructed to Call a Private Physician ☐ Referred to This Office ☐ Other _____

Did you have any previous Workers Compensation injuries? ☐ No ☐ Yes If yes, date(s) of previous injuries? _____

Describe previous Workers Compensation injuries _____

Have you ever received Chiropractic Care? ☐ No ☐ Yes If yes, what was the name of the Chiropractic Physician? _____

What was the approximate date of your last visit? _____ What were you being treated for? _____

DUTIES UNDER DURESS SUMMARY

Check the day-to-day living **duties that are difficult or painful** for you to do as a result of your injuries from this work injury.

What is your job description? _____ Check all Activities that you have difficulty with at work below:

☐ Lifting ☐ Bending ☐ Sitting ☐ Walking ☐ Computer Duties ☐ Other _____

Check all Activities that you have difficulty with doing School/Studies:

☐ Lifting ☐ Bending ☐ Sitting ☐ Walking ☐ Computer Duties ☐ Studying ☐ Other _____

Check all Activities that you have difficulty with doing Domestic Duties:

☐ Vacuuming ☐ Cleaning ☐ Preparing Meals ☐ Taking Care of Kids ☐ Other _____

Check all Activities that you have difficulty with doing Household Duties:

☐ Yardwork ☐ Transportation ☐ Shopping ☐ Taking Out Trash ☐ Other _____

LOSS OF ENJOYMENT SUMMARY

Check all activities as they relate to your lifestyle, work and daily activities that you normally would be enjoying, but are currently **not enjoying** or have had to reduce the time you are capable of experiencing them as a result of this work injury.

What is your job description? _____ Check all Activities that you have difficulty with at work:

☐ Lifting ☐ Bending ☐ Sitting ☐ Walking ☐ Computer Duties ☐ Other _____

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LOSS OF ENJOYMENT SUMMARY continued…

Check all Activities that you have difficulty with doing School/Studies:

☐ Lifting ☐ Bending ☐ Sitting ☐ Walking ☐ Computer Duties ☐ Studying ☐ Other _____

Check all Activities that you have difficulty with doing Domestic Duties:

☐ Vacuuming ☐ Cleaning ☐ Preparing Meals ☐ Taking Care of Kids ☐ Other _____

Check all Activities that you have difficulty with doing Household Duties:

☐ Yardwork ☐ Transportation ☐ Shopping ☐ Taking Out Trash ☐ Other _____

Check and name all Sports Activities that are having difficulty with as a result of your injuries from this work injury.

☐ Social _____ ☐ Competitive _____ ☐ Regional _____ ☐Other _____

DESIGNATION OF AUTHORIZED REPRESENTATIVE

I, _____, do hereby designate Dr. Darren Cissell, D.C. of Ridge Chiropractic Center, (hereafter
(Please print your name)
referred to as "my doctor"), to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1 (b) 4 to act on my behalf to pursue claims and exercise all rights connected with my employee health care benefits plan, with result of the services I receive from the above named doctor. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefits determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies, all in connection with medical or other health care expense(s) as the result of the services I received from my doctor.

My signature below certifies that the above information is true and complete to the best of my knowledge.

_____ _____ _____
Name of Patient (Printed) Signature of Patient Date

_____ _____
(Signature of Legal Representative if patient a minor) Relationship (e.g. Guardian or Parent if patient a minor)