

## Workers Compensation / No-Fault / Personal Injury Information Packet

Please enter your information.

First Name:	Middle Initials:	Last Name:	Date of Birth:
_____	_____	_____	_____
Gender: <input type="radio"/> Female <input type="radio"/> Male	Occupation:	Employer Name:	
_____	_____	_____	

### Accident/Injury Information

Are you out of work because of this accident/injury? <input type="radio"/> Yes <input type="radio"/> No	Select which State the Accident/Injury happened? <input type="radio"/> New Jersey (NJ) <input type="radio"/> New York (NY) <input type="radio"/> Other State	Other State(If Applicable) _____
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List any work restrictions you have as a result from this accident:

\_\_\_\_\_  
\_\_\_\_\_

Which part(s) of the body were effected as a result of the accident?

\_\_\_\_\_

Describe how accident/injury happened? (Need Exact Details)

\_\_\_\_\_  
\_\_\_\_\_

Did you have any pain/discomfort at all before the accident/Injury? (Unrelated to this accident/injury)  
 Yes  No

If you had pain before the injury, please explain where and why:

\_\_\_\_\_  
\_\_\_\_\_

Have you already seen a Doctor for this accident/Injury? (Medical doctor or Chiropractor)  
 Yes  No

What doctors have you seen for this accident? (Name of Doctor/Type of Doctor/City/ Last time seen)

\_\_\_\_\_  
\_\_\_\_\_

Have you prescribed any treatment(s) or medications related to this Accident/Injury?

Please list of all treatments and/or medications received or currently being taken due to the accident.

PREVIOUS CLAIMS/ ACCIDENTS ( UNRELATED TO THIS ACCIDENT/INJURY )

Have you ever seen a chiropractor before?

Yes  No

If yes, please provide their information here and the last time you were seen?

Have you been involved in a Motor vehicle Accident previously?

Yes  No

If Yes, please provide the date, details of the accident, and any injuries or medical treatment received.

Have you had any other workers compensation claims?

If yes, Please provide the details of the accident(s):

Draw on the image below where you have pain/discomfort:

