Kingston West Family Chiropractic
dedicated to excellence in natural family health
Dr. Adrina K. Patterson D.C.

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Patient's Name: _____ Date: _____

Date of Birth: (d)_____(m)_____(y)_____ SIN # _____

Was a WSIB Claim filed? (Contact occupational health and your family physician)

- ○ Yes No

If yes, when? _____

Claims Adjudicator: _____

Contact # _____

Claim # assigned to you: _____

Employer's name: _____

Contact person: _____

Telephone number: _____ Fax number: _____

Email: _____

Address: _____

Job title/ description: _____

Length of time at current job: _____

□ Full time □ Part time

Date of Accident: _____

Accident description: _____

_____

_____

Onset of symptoms: _____

Current Symptoms/Complaints:_____

_____

Medications/dosages: _____

_____

Date of first treatment: _____

Name of First Treating Health Care Provider:_____

Time missed from work? □Yes □No

If yes, start date: _____

Are you back to work now? □ Yes □ No