

**Myler Chiropractic**  
62 Elm Street, Potsdam, NY 13676  
**Worker's Compensation Injury Report**

**Patient Information**

Your Name \_\_\_\_\_

Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Home Phone #

\_\_\_\_\_ WCB Case # (if known) \_\_\_\_\_ Carrier Case #

\_\_\_\_\_

Your mailing address \_\_\_\_\_

\_\_\_\_\_

Date of Injury/Illness \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender M  
F

On the date of the injury, what was your job title or job description?

\_\_\_\_\_

On the date of the injury, what were your usual work activities?

\_\_\_\_\_

**Employer Information**

Employer where the injury occurred \_\_\_\_\_

Employer phone # \_\_\_\_\_ Employer contact person

\_\_\_\_\_

Employer address \_\_\_\_\_

\_\_\_\_\_

**Billing Information**

Employer's Insurance Carrier \_\_\_\_\_

Insurance Carrier's Address \_\_\_\_\_

\_\_\_\_\_

**History**

How & where did the injury happen?

\_\_\_\_\_

Has this injury been treated by anyone other than Dr. Myler? (include hospitalization or surgery.) \_\_\_\_\_

---

---

**Injury**

What symptoms are you having? Include areas of pain.

---

---

---

---

Are there any activities you cannot do?

---

---

---

Have you ever had a similar injury? If yes, describe.

---

---

---

**Work Status**

Have you missed any days of work? List dates

---

Are you working now? Yes No

**Attorney Information**

Have you spoken with an attorney about this injury? Yes No

Attorney name \_\_\_\_\_ Phone # \_\_\_\_\_

Attorney Address \_\_\_\_\_

---

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_