

**Needham Family Chiropractic**  
Otto Todorov, DC, CCSP, ART provider  
105 Chestnut Street, Suite 35, Needham, MA 02492  
Phone: (781) 444-3772 Fax: (781) 444-7427  
E-mail: [ottochiropractor@msn.com](mailto:ottochiropractor@msn.com)

**WORKMAN'S COMPENSATION**

Submission Date: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Location: \_\_\_\_\_

Describe Injury: \_\_\_\_\_

\_\_\_\_\_

Did you report the accident to employer/supervisor? \_\_\_ Yes \_\_\_ No

Name and phone number of employer contact person: \_\_\_\_\_

\_\_\_\_\_

**CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Headache            | <input type="checkbox"/> Neck Pain        | <input type="checkbox"/> Neck Stiff           |
| <input type="checkbox"/> Sleeping Problems   | <input type="checkbox"/> Back Pain        | <input type="checkbox"/> Nervousness          |
| <input type="checkbox"/> Tension             | <input type="checkbox"/> Irritability     | <input type="checkbox"/> Chest Pain           |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Head Seems Heavy | <input type="checkbox"/> Pins/Needles in Arms |
| <input type="checkbox"/> Pins/Needles        | <input type="checkbox"/> Numb in Fingers  | <input type="checkbox"/> Numb in Toes         |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fatigue          | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> Light bothers eyes  | <input type="checkbox"/> Loss of Memory   | <input type="checkbox"/> Ears Ring            |
| <input type="checkbox"/> Face Flushed        | <input type="checkbox"/> Buzzing Ears     | <input type="checkbox"/> Loss of Balance      |
| <input type="checkbox"/> Fainting Spells     | <input type="checkbox"/> Loss of Smell    | <input type="checkbox"/> Loss of Taste        |
| <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Feet Cold        | <input type="checkbox"/> Hands Cold           |
| <input type="checkbox"/> Stomach Upset       | <input type="checkbox"/> Constipation     | <input type="checkbox"/> Cold Sweats          |

Symptoms other than above: \_\_\_\_\_

\_\_\_\_\_

Have you lost any days of work? \_\_\_ Yes \_\_\_ No     Dates: \_\_\_\_\_

Is there an attorney representing you for your worker's compensation injury? \_\_\_ Yes \_\_\_ No

If yes, please provide Attorney's name and phone number: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_