

Workers' Compensation Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name _____ Sex _____ Marital Status _____ Date of Birth _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Who referred you to our office? _____

(Indicate if child, student, housewife, unemployed, retired)

Social Business Company _____

Sec. # _____ Phone _____ Name _____ Location _____

Spouse's Spouse's Spouse's _____

First Name _____ Soc. Sec. # _____ Employer _____ Location _____

Please explain in detail how your accident happened _____

Have you retained an attorney? Yes No Litigation? Yes No Maybe

If so, name and address _____

Give time and date present injury occurred _____ AM PM _____ 19 _____

Where did you feel pain immediately after the accident? _____

Did you return to work? Yes No If so, date returned to work _____

★ Did you consult any other doctor? Yes No

If so, give doctor's name _____ D.C., M.D., D.O., D.D.S.

Doctor's diagnosis _____

What treatments did you receive? _____

Have you ever injured this area before? Yes No If so, when? _____

If injured before, did you lose time from work? Yes No

If you lost time from work with injuries prior to this injury, give name of doctor or doctors consulted _____

Do any other diseases or accidents affect your employment? Yes No If so, explain _____

In your work do you have to favor any part of your body? Yes No If so, explain _____

Do you have a history of absenteeism caused from accidents on the job? Yes No

Have you ever had a Workmen's Compensation claim before? Yes No

Before the injury were you capable of working on an equal basis with others your age? Yes No

Are your work activities restricted as a result of this accident? Yes No

Since this injury are your symptoms improving? getting worse? the same?

13. What are your PRESENT complaints and symptoms? _____

14. Do you have any congenital (from birth) factors which relate to this problem? () Yes () No If yes, please describe: _____

15. Do you have any previous illnesses which relate to this case? () Yes () No If yes, please describe: _____

16. Have you ever been involved in an accident before? () Yes () No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received. _____

17. Where were you taken after the accident? _____

18. Have you been treated by another doctor since the accident? () Yes () No If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____

19. Since this injury occurred, are your symptoms: () Improving () Getting Worse () Same

20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head Seems Too Heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> _____ |

Symptoms Other Than Above _____

21. Have you lost time from work as a result of this accident? () Yes () No If yes, please complete this question.

a. Last Day Worked: _____

b. Type of Employment: _____

c. Present Salary: _____

d. Are you being compensated for time lost from work? () Yes () No If yes, please state type of compensation you are receiving: _____

22. Do you notice any activity restrictions as a result of this injury? () Yes () No If yes, please describe, in detail: _____

23. Other pertinent information: _____

24. Do you need assistance in completing your insurance application form? () Yes () No

DATE

PATIENT'S SIGNATURE