WORKERS' COMPENSATION QUESTIONAIRE

Dear patient: **Today's Date:** ____________________

Please complete this form in it's entirety. This information is necessary to help us assess your need for care and to accurately document your treatment file. If we do not sincerely believe your condition will respond to chiropractic care, we will not accept you as a patient. Thank you.

GENERAL INFORMATION

Name ____________________________________ Sex ___ DOB ___/___/_____ Home Ph. ___________________

Address ____ City ____________________ State ____ Zip ________

Employer ____ Occupation ________________________

Employer Address ______________________________________ Employer Ph. (____) ___________ O.K to call? __

Name of Employer HR or Business Manager ____

Has this injury been reported to your Manager/Supervisor? ____Yes ____No

NATURE OF ACCIDENT

1. What was the time and date of this present injury? _____M _____D 200___ ___:____ AM / PM
2. Please explain in your own words how your accident happened. ____

____

____

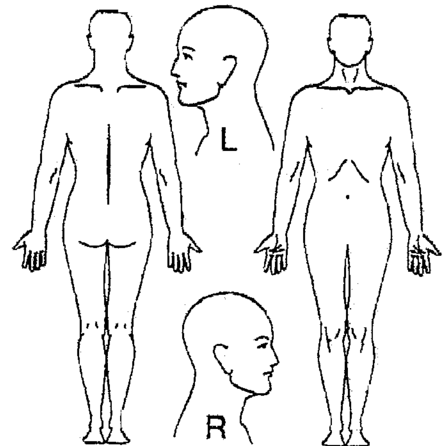
3. Where did you feel pain or unusual feeling immediately after the accident?

____

____

____

(please indicate the areas on the diagram)



4. Were you unconscious as a result of the injury? __N __Y

   If yes, how long? ______________________________

5. Were you bleeding as a result of the injury? ___N ___Y
6. Did you leave the work area after the accident for medical attention? ___________________________________

____

7. Did you consult any other doctor? ___N ___Y If yes, what was the doctor's name?

____ ____DC ____MD ____DO ____DDS

8. Describe the doctor's diagnosis. ____
9. What treatment did you receive? ____
10. Are you still under a doctor's care? ___N ___Y If yes, please explain. _______________________________

____

PAST HISTORY

1. Have you ever injured this area before? ___ N ___Y If yes, when? ______________________________
2. If injured before, did you lose time from work? ___N ___Y If yes, when and how long? _____________
   ____
3. If you lost time from work with injuries prior to this injury, give names of doctor or doctors consulted.
   ____
4. Have you been involved in any previous accidents of any kind (personal injury, auto accident or Workers' Compensation) ___N ___Y If yes, please explain dates and details ____________________
   ____
   ____
5. Have you been treated by a chiropractor before? ___N ___Y If yes, who and when?_________________
   ____

PRESENT INFORMATION/DISABILITY

1. Have you returned to work? ___N ___Y If yes, date you returned to work. ________________________
2. Job description ____
3. Are your work activities restricted as a result of this accident? ___N ___Y If yes, please explain _______
   ____
4. Do you notice any activity restrictions as a result of this injury? ___N ___Y If yes, please explain ______
   ____
5. Since this injury, have your symptoms: ____ improving ____ getting worse, or ______ the same?
6. Do any other diseases or accidents affect your employment? ___N ___Y If yes, please explain________
   ____

LEGAL REPRESENTATION

1. Have you retained an attorney? ___N ___Y If yes, name and address ____________________________
   ____
2. Have you ever had a Workers' Compensation claim before? ___N ___Y

I certify that I have read and understand the above information. The above questions have been accurately answered to the best of my knowledge. I understand that omitting or providing incorrect information can be dangerous to my health and/or could jeopardize my workers' compensation claim.

______________________________ ______________________________

Patient's Signature **Date**

____

Print Name