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 posssible while completing this form. Thank you.

Name________________________ Sex______ Marital Status ________ Date of Birth ________________ Home Phone ____________________

Address________________________ City________________________ State________________________

Occupation________________________ Who referred you to our office?________________________
(Indicate if child, student, housewife, unemployed, retired)

Social Sec. # ____________________ Business Phone ____________________ Company Name ________________________ Location ____________________

Spouse's First Name ________________ Spouse's Soc. Sec. # ________________ Spouse's Employer ________________________ Location ____________________

Please explain in detail how your accident happened____

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

If so, name and address____

Give time and date present injury occured______________________ # AM # PM ______________________ 20_______

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

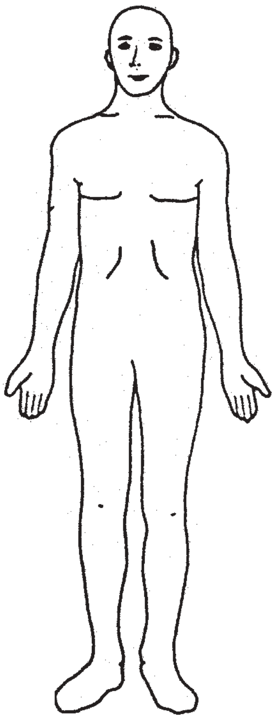
Since this injury are your symptoms # improving? # getting worse? # the same?

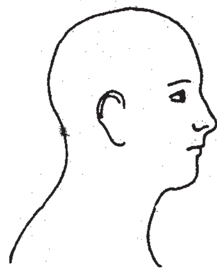
HEALTH QUESTIONNAIRE:

Symptoms I've had since accident______________________________

Symptoms I had before accident______________________________

Please mark your areas of pain on the figures below.





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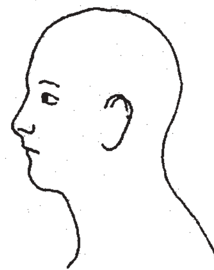

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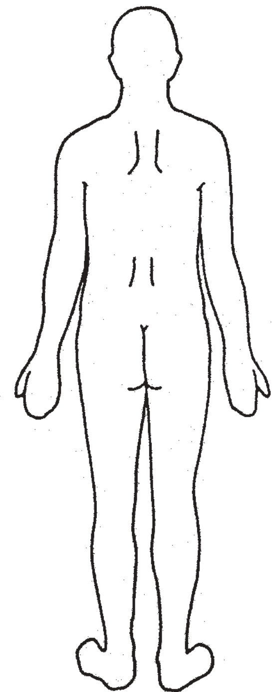

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Patient's Signature

— — — — — — — — — — — — — — DO NOT WRITE BELOW THIS LINE — — — — — — — — — — — — — —

Patient accepted? # Yes # No Doctor's Signature________________________