

# 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.

Patient Name _____			
Last		First	
M.I.			
Male <input type="checkbox"/>	Female <input type="checkbox"/>	I prefer to be called _____	
Birthdate _____	Age _____	SS# _____	- - _____
Street Address _____		Apartment _____	
City _____		State _____	Zip Code _____
Home Phone _____	Work Phone _____	Mobile _____	
Occupation _____			
<small>(Please indicate if child, student, housewife, unemployed, retired)</small>			
Employer _____		How Long? _____	
Employer Address _____			
City _____		State _____	Zip Code _____
Status: Minor <input type="checkbox"/>	Single <input type="checkbox"/>	Married <input type="checkbox"/>	Divorced <input type="checkbox"/>
Separated <input type="checkbox"/>	Widowed <input type="checkbox"/>		
Spouse's Name _____		Spouse's SS# _____	
Spouse's Employer _____		Location _____	
Who referred you to our office? _____			

## Accident Information

Please explain in detail how your accident happened _____	
_____	
_____	
_____	
_____	
_____	
Have you retained an attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, name and address of attorney _____	
Time and date injury occurred _____	
Where did you feel pain immediately after the accident? _____	
What symptoms have appeared since accident? _____	
_____	
Did you miss any work due to this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, did you return to work? <input type="checkbox"/> Yes <input type="checkbox"/> No Date returned: _____	
Did you consult any other doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Doctor's Name _____ <input type="checkbox"/> D.C. <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> D.D.S.	
Doctor's diagnosis _____	
What treatments did you receive? _____	
Have you ever injured this area before? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when? _____	
If injured previously, did you lose time from work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you lost time from work with injuries prior to this injury, give name(s) of doctor(s) consulted: _____	

Accident Information, cont'd.

Do any other diseases or accidents affect your employment?  Yes  No

If so, explain: \_\_\_\_\_

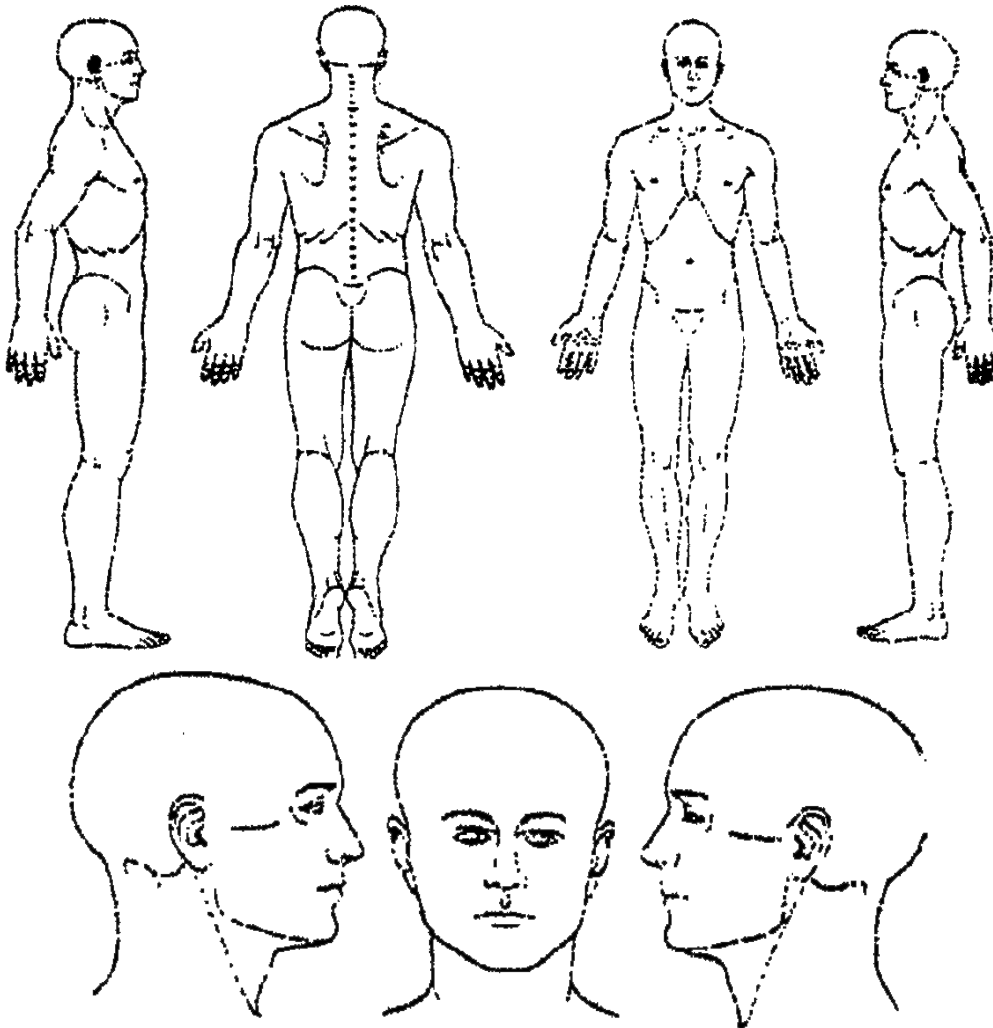
Have you ever had a Workers' Compensation claim before?  Yes  No

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

If so, describe: \_\_\_\_\_

Since this injury, are your symptoms:  improving?  worsening?  the same?

Please mark your areas of discomfort with an "x" on the figure below.



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

If patient is under 18:  
Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_