

WORKERS COMPENSATION QUESTIONNAIRE

This information confidential. We need information because we care enough to want to know. 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. Please be as neat and accurate as possible. Thank you.

Name \_\_\_\_\_ Sex: M or F DateBirth \_\_\_\_\_ Phone# \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Occupation \_\_\_\_\_ Who referred you to our office? \_\_\_\_\_

Company Name/Address \_\_\_\_\_

Company Phone # \_\_\_\_\_ Date of Accident: \_\_\_\_\_

Please explain in detail how your accident happened: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Time of accident: \_\_\_\_\_ am pm Did you return to work? Yes No When? \_\_\_\_\_

Any other Doctors consulted? Any Diagnostics? List Names/Addresses/Dates: \_\_\_\_\_

\_\_\_\_\_

Diagnosis & Treatments received: \_\_\_\_\_

\_\_\_\_\_

Have you been injured in this area before? Yes No When? \_\_\_\_\_

Did you lose time from work then? Yes No If yes, Doctor's name(s) \_\_\_\_\_

Any other Diseases or Accidents affect your employment? Yes No Explain: \_\_\_\_\_

\_\_\_\_\_

In your work do you have to FAVOR any part of your body? Yes No Explain: \_\_\_\_\_

\_\_\_\_\_

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

Have you ever had a Workmens Compensation claim before? Yes No

Before this 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

Have you retained an attorney: Yes No Litigation: Yes No

Attorney Name/Address: \_\_\_\_\_

\_\_\_\_\_

Patient Signature/Date

Patient Accepted? Yes No \_\_\_\_\_

Doctor's Signature