

# WORKERS' COMPENSATION QUESTIONNAIRE

Dear Patient:

Date \_\_\_\_\_

We need this confidential information answered completely to help us assess your need for care. 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 \_\_\_\_ Marital Status \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

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

Occupation \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ OK to call there? \_\_\_\_\_

## Nature of Accident:

1. What was the time and date of this present injury? \_\_\_\_\_ AM \_\_\_\_\_ PM \_\_\_\_\_ 19\_\_\_\_\_

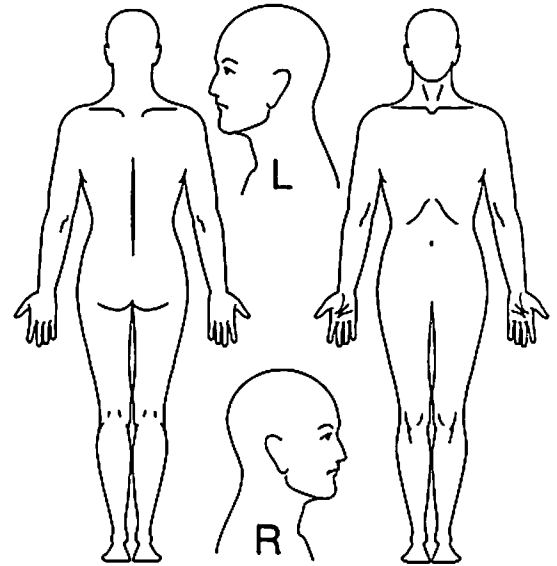
2. Please explain in detail how your accident happened.  
(Please include location, condition of area and equipment involved.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING IMMEDIATELY AFTER ACCIDENT.

Mark the areas on this body where you felt the described sensations. Use the appropriate symbols in all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
XXXXXXXXXX	.....	OOOOOO	WWWWW	
XXXXXXXXXX	.....	OOOOOO	WWWWW	
XXXXXXXXXX	.....	OOOOOO	WWWWW	

3. Where did you feel pain or unusual feeling immediately after the accident? (Please show the areas on the diagram also.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



4. Were you unconscious as a result of the injury? \_\_\_\_\_  
If yes, how long? \_\_\_\_\_

5. Were you bleeding as a result of the injury? \_\_\_\_\_

6. Did you leave the work area after the accident to seek medical attention? \_\_\_\_\_ Please explain \_\_\_\_\_  
\_\_\_\_\_

7. Did you consult any other doctor? \_\_\_\_\_

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? \_\_\_\_\_ If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

**Past History:**

1. Have you ever injured this area before? \_\_\_\_\_ If yes, when? \_\_\_\_\_
2. If injured before, did you lose time from work? \_\_\_\_\_
3. If you lost time from work with injuries prior to this injury, give name of doctor or doctors consulted.  
\_\_\_\_\_
4. Have you been involved in any previous accidents of any kind (personal injury, automobile accident or workers' compensation)? \_\_\_\_\_ If yes, please explain dates and details \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Have you been treated previously by a chiropractor? \_\_\_\_\_ If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

**Present Information/Disability:**

1. Have you returned to work? \_\_\_\_\_ If yes, date returned to work \_\_\_\_\_
2. Job description \_\_\_\_\_
3. Do you have to favor any part of your body in your work? \_\_\_\_\_ If yes, please explain \_\_\_\_\_  
\_\_\_\_\_
4. Are your work activities restricted as a result of this accident? \_\_\_\_\_ If yes, please explain \_\_\_\_\_  
\_\_\_\_\_
5. Since this injury, are your symptoms: improving \_\_\_\_\_ , getting worse \_\_\_\_\_ or the same \_\_\_\_\_ ?  
Please explain \_\_\_\_\_
6. Do any other diseases or accidents affect your employment? \_\_\_\_\_ If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

**Legal Representation:**

1. Have you retained an attorney? \_\_\_\_\_ If yes, name and address \_\_\_\_\_  
\_\_\_\_\_
2. Have you ever had a Workers' Compensation claim before? \_\_\_\_\_

I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor's Signature (upon review)

\_\_\_\_\_  
Date