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 __________ YEAR____

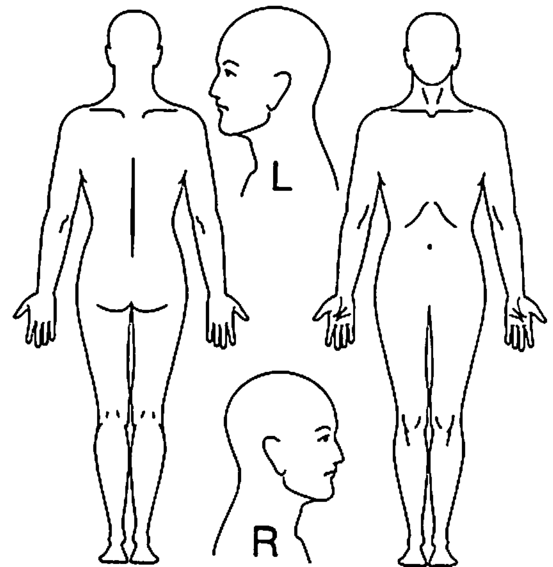
2. Please explain in detail how your accident happened. (Please include location, condition of area and equipment involved.) ______________________

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
xxxxxxxxxxx	....	oooooo	\\\\\\\\	IIIIIIIIIIII
xxxxxxxxxxx	....	oooooo	\\\\\\\\	IIIIIIIIIIII
xxxxxxxxxxx	....	oooooo	\\\\\\\\	IIIIIIIIIIII

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

DELAWARE WORKERS' COMPENSATION
PHYSICIAN'S REPORT OF WORKER'S COMPENSATION INJURY
A COPY OF THIS REPORT MUST BE SENT TO THE INJURED WORKER, EMPLOYER AND THE INSURER

REPORT TYPE ___Initial ___Progress ___Closing

WORKER'S NAME________________________________

DOB ________________ Employer Name ________________
Date of Injury ________________ Employer Phone/Fax ________________
EXAM DATE ________________ Insurer Name ________________
Physician's Phone/Fax________________ Insurer Claim No. ________________
Insurer Phone/Fax ________________

INITIAL VISIT ONLY
Injured worker's description of accident/injury________________________________
____

WORK RELATED MEDICAL DIAGNOSIS (ES) ________________________________
____

TREATMENT PLAN:
Diagnostic Tests________________________________
Procedures________________________________
Therapy________________________________
Medications________________________________

Hrs. per day patient can work: (circle one) 8 6 4 2 0

D.O.T. Classification of Work (Circle one)

Sedentary Exerting up to 10 lbs. of force *occasionally* and/or a negligible amount of force *frequently* to lift, carry, push, pull or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.

Light Exerting up to 20 lbs. of force *occasionally* and/or up to 10 lbs. of force *frequently* and/or negligible amount of force *constantly* to move objects. Physical demand requirements are in excess of those for Sedentary Work.

Medium Exerting 20 to 50 lbs. of force *occasionally* and/or 10 to 25 lbs. of force *frequently* and or greater than negligible up to 10 lbs. of force *constantly* to move objects. Physical Demand requirements are in excess of those for Light Work.

Heavy Exerting 50 to 100 lbs. of force *occasionally* and/or 25 to 50 lbs. of force *frequently* and/or 10 to 20 lbs. of force *constantly* to move objects. Physical Demand requirements are in excess of those for Medium Work.

Very Heavy Exerting in excess of 100 lbs. of force *occasionally* and/or in excess of 50 lbs. of force *frequently* and/or in excess of 20 lbs. of force *constantly* to move objects. Physical Demand requirements are in excess of those for Heavy Work.

Definitions:
Occasionally: activity or condition exists up to 1/3 of the time
Frequently: activity or condition exists from 1/3 to 2/3 of the time
Constantly: activity or condition exists 2/3 or more of the time

Work Postures/Positional tolerances: Comment as appropriate in the space provided regarding the patient's abilities/limitations for the following Postures/Positions. (e.g. Sitting: No more than 30 minutes continuously)

Sitting: ________________ Squatting: ________________
Standing: ________________ Crawling: ________________
Walking: ________________ Climbing: ________________
Driving: ________________ Repeated arm motions: ________________
Bending: ________________ Repetitive use of wrist/hands: ________________
Turn/Twist: ________________ Reaching up above shoulder: ________________
Kneeling: ________________ Foot controls: ________________

Comments:________________________________
____
____

Above safe work capacities are: temporary_______ permanent_______ anticipate full duty release___________

Return to work modified duty start date: ________________________________

RELEASE TO FULL DUTY WITH NO RESTRICTIONS (Please Circle) YES (Start date______________) NO

Physician Signature: ________________________ Date: ________________

Physician Name: (Please print)________________________ Certified Provider:: YES NO

PROVIDER FORM

Revised 10/2009