

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.

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 _____ Business _____ Company _____
Sec. # _____ Phone _____ Name _____ Location _____

Spouse's _____ Spouse's _____ Spouse's _____
First Name _____ Soc. Sec. # _____ Employer _____ Location _____

Please explain in detail how your accident happened _____

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

If so, name and address _____

Give time and date present injury occurred _____ # 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

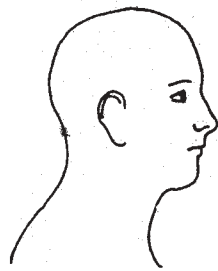
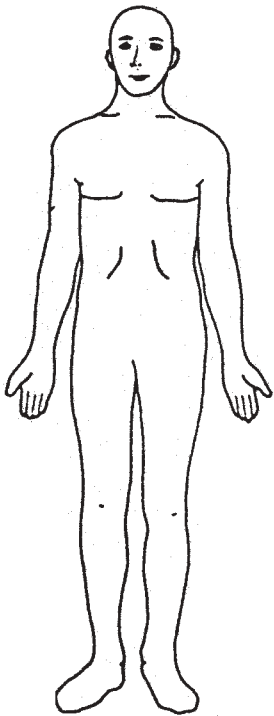
Since this injury are your symptoms # improving? # getting worse? # the same?

HEALTH QUESTIONNAIRE:

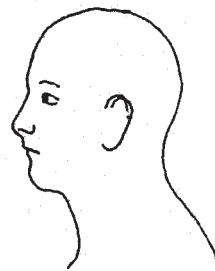
Symptoms I've had since accident _____

Symptoms I had before accident _____

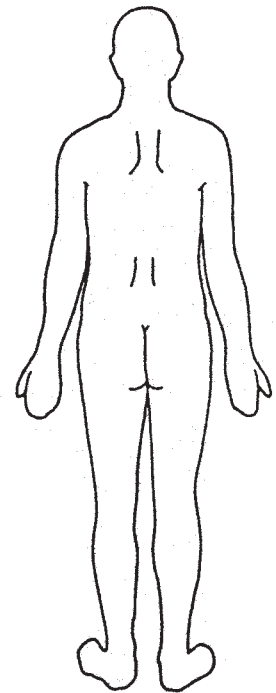
Please mark your areas of pain on the figures below.



R



L



Patient's Signature

----- DO NOT WRITE BELOW THIS LINE -----

Patient accepted? # Yes # No Doctor's Signature _____