# WORKER'S COMPENSATION QUESTIONNAIRE

**Please answer all questions completely**

Dear Patient: This information is considered confidential. We need this information in order to 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 accident properly, please be as neat and accurate as possible while completing this form. Thank you.

Name______________________________________________________________________

Employer's Name_______________________ Employer's Phone____________________ City_______________________________

Occupation_________________________________________________________________

Give time and date present injury occurred______________ □ AM □ PM ________20_________________

Has this accident been reported to your employer? □ Yes □ No. When? ___________________________

To Whom? _________________________________________________________________

Please explain in detail how your accident happened_____________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Where did you feel pain immediately after the accident? _________________________________________

If you were taken to the hospital, which one? ___________________________________________________

Have you lost time from work as a result of this accident? □ Yes □ No
If yes, when was your last day worked? _______________________________________________________

Are you being compensated for time lost from work? □ Yes □ No

Did you return to work? □ Yes □ No If yes, date returned to work? _________________________________

Did you consult any other doctor? □ Yes □ No

If yes, doctor's name_____________________________________________ □ D.C. □ M.D. □ D.O. □ D.D.S.
Diagnosis _________________________________________________________________

What treatments did you receive?____________________________________________________________

In your work do you have to favor any part of your body? □ Yes □ No
If yes, 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 of your age? □ Yes □ No

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

Since the injury occurred, are your symptoms: □ Improving □ Getting Worse □ Same

Have you retained an attorney? □ Yes □ No Litigation □ Yes □ No □ Maybe
If so, name and address ______________________________________________

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 yes, explain ________
__________________________________________________________________
__________________________________________________________________

Do you have any congenital (from birth) factors or previous illness, which relate to this case? □ Yes □ No
If yes, describe _________________________________________________
__________________________________________________________________

Have you ever been involved in an accident before? If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received ________________________________
__________________________________________________________________
__________________________________________________________________

What type of treatment did you receive? ____________________________________
__________________________________________________________________

**Date** ____________________ **Patient's Signature** ______________________________