Last Name: ________________________ First Name: _______________Account #:_______________

Workers Compensation Questionnaire

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: __________________

Address: ____ City: ________________________ State: ______ Zip: ______________

Home Phone: _________________________ Cell Phone: _________________________ Work Phone: _________________________

Occupation: _______________________ Social Security #: ________________ Who referred you to our clinic: _________________

Employer: ____________________________________Employers Address: ____

Insurance Company: ____ Claim #:____________________________________

Name of Insurance Adjustor: ________________________________ Phone #:___________________________ Ext: _______________

Date & Time of Accident: ______________________ Location of Accident: _____________________Reported to: ______________

Please explain in detail how your accident happened: ____

____

____

____

Were you knocked unconscious: _______ Were you taken to the Hospital/Doctor/ER: ____

Where did you feel pain immediately: _____________________________ what treatment was given: ___________________________

Have you consulted any other doctors for these conditions since the accident:_______ Name:__________________________________

Location: ____

What treatment were you, and are you having for these conditions:____

____

____

Have you had any complaints in the involved area before: ______ when and what treatment: ___________________________________

Prior to the accident were you capable of working on an equal basis with others your age: ____________________________________

Have your work activities been restricted since the accident: ______ how: ____

Have you retained an attorney:_____ Their Name:____________________________ Phone:___________________________________

Authorization: I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Worker Compensation benefits is denied. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility for the payment of all charges.

Sign: _________________________________ Date: ________________ Parent or Guardian: __________________________