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.

PERSONAL INFORMATION

Name ______________________________

Sex ______ Marital Status __________

Date of Birth ______________________

Home Phone ______________________

Address ____________________________

City/State/Zip ______________________

Occupation _______________________
(Indicate if child, student, housewife, unemployed, retired)

Who referred you
to our office? ______________________

Social Security # ___________________

Business Phone ____________________

Company Name ___________________

Location __________________________

SPOUSE'S INFORMATION

Name ______________________________

Social Security # ___________________

Employer __________________________

Location __________________________

Community Chiropractic

16 Canalview Mall
Fulton, NY 13069

(315) 592-4740

ACCIDENT INFORMATION/DETAILS

Please explain in detail how your accident happened ________________
____
____
____

Time and date present injury occurred ______ am / pm ______________

Where did you feel pain immediately after the accident? _____________
____

Did you return to work? Yes No
If so, date returned to work ___________________________

Have you ever injured this area before? Yes No
If so, date returned to work ___________________________

If injured before, did you lose time from work? Yes No

Before the injury, were you capable of
working on an equal basis with others your age? Yes No

Have you tried any home remedies for your condition such as aspirin, heating pad, ice packs, etc.? ______________________________________

What aggravates your condition? ____________________________
(For example: walking, sitting, bending, etc.)

Is there any position that you can get
into that makes your condition better? ________________________

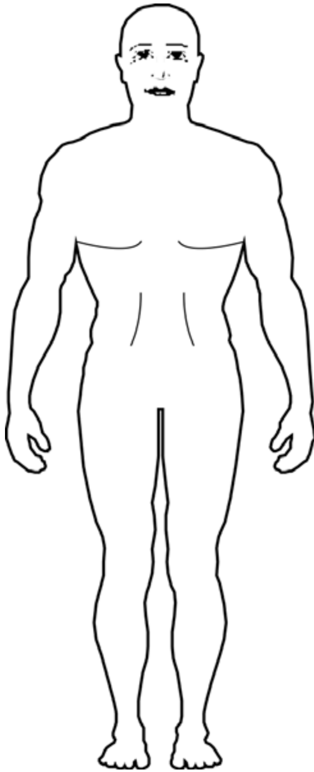
Does your condition interfere with your work? Yes No
If so, how? ____

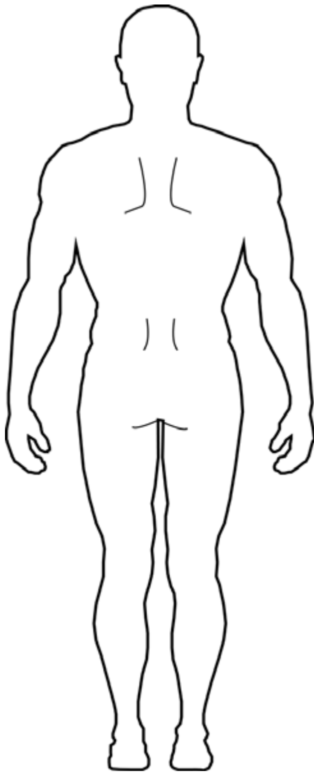
Since this injury, are your symptoms:
Getting better Worse About the same

List all medications you are now taking ________________________
____

List any other comments relative to this accident __________________
____
____
____

Please mark your areas of pain on the figures below.





Accident Information/Details Continued

Have you retained an attorney? Yes No

Litigation? Yes No Maybe

If so, name and address ______________________________

____

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 treatment did you receive? _________________________________

____

Do any other diseases or accidents affect your employment? Yes No

If so, please explain __________________________________

If you lost time from work with injuries prior to this injury, give name of doctor(s) consulted ________________

____

In your work do you have to favor any part of your body? Yes No

If so, please 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

List all previous surgeries ____

____

____

List secondary complaints not directly related to this accident ________

____

____

Other comments ____

____

____

____

____

____

Patient Signature: ____________________________ Date: ___________