WORKERS COMPENSATION QUESTIONNAIRE

This information will be strictly confidential. Your answers will help us determine if chiropractic care will benefit you. Plesase print and be as accurate and complete as possible.

Thank you – Pank Chiropractic

PATIENT INFORMATION

NAME Last	First	Middle	DATE

ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	WORK PHONE

SOCIAL SECURITY NUMBER	DATE OF BIRTH	HEIGHT	WEIGHT	SEX

EMPLOYER	OCCUPATION

BUSINESS ADDRESS	EMAIL ADDRESS

ACCIDENT INFORMATION

GIVE DETAILS OF HOW ACCIDENT OCCURRED

DATE & TIME OF ACCIDENT:	WAS YOUR EMPLOYER NOTIFIED? YES NO (Circle One) Name of Person Notified:	HAS YOUR EMPLOYER AUTHORIZED TREATEMENT? Y / N NAME OF PERSONE AUTHORIZING:

PLEASE DESCRIBE YOUR INJURIES AND SYMPTOMS RESULTING FROM THIS ACCIDENT:

DID YOU CONSULT ANOTHER DOCTOR? YES NO (Circle One)	DOCTORS NAME	HOW OFTEN DO YOU SEE THIS DOCTOR?

WHAT TREATMENTAND DIAGNOSIS WAS GIVEN?

ANY PRIOR INJURUES OR SYMPTOMS TO THE SAME AREA(S)? IF YES, PLEASE DESCRIBE:

SINCE THE INJURY PLEASE CIRCLE ONE OF THE FOLLOWING: IMPROVING THE SAME GETTING WORSE

DID YOU OR ARE YOU STILL TAKING ANY MEDICATIONS FOR THIS INJURY? YES NO List of Yes:

LIST TWO MAJOR COMPLAINTS, AND CIRCLE THE INTENSITY OF PAIN

Low 1-3, Moderate 4-6, Intense 7-9, Emergency 10

COMPLAINT 1: _____ 1 2 3 4 5 6 7 8 9 10

COMPLAINT 2: _____ 1 2 3 4 5 6 7 8 9 10

AFTER THE ACCIDENT, DID YOU RETURN TO WORK?
YES NO (circle) DATE:

HAS THIS INJURY RESTRICTED YOUR WORK?
YES NO (circle) HOW:

HAVE YOU EVER HAD A WORKERS COMPENSATION CLAIM BEFORE OR LOST WORK DUE TO PRIOR INJURIES?
YES NO (circle) EXPLAIN:

BEFORE THIS INJURY WERE YOU ABLE TO WORK ON AN EQUAL BASIS WITH OTHERS YOUR AGE?
YES NO (circle) EXPLAIN:

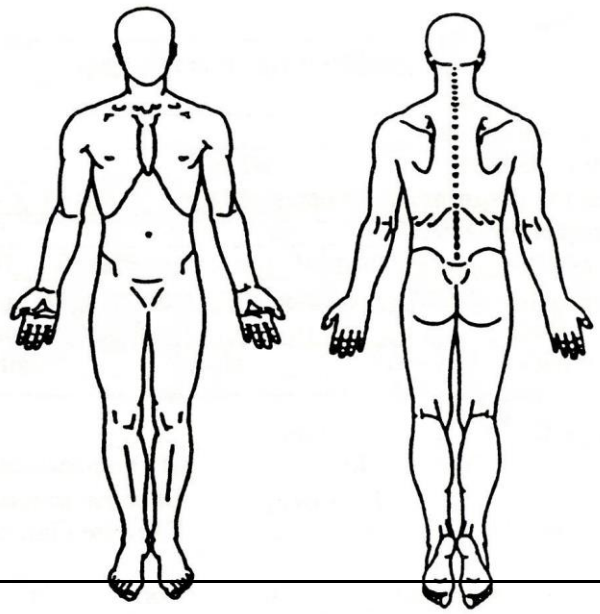
DO YOU HAVE ANY OTHER CONDITIONS THAT AFFECT YOUR WORK?
YES NO (circle) EXPLAIN:

DO YOU FAVOR ANY BODY PARK WHILE WORKING?
YES NO (circle) WHICH ONE:

HAVE YOU RETAINED AN ATTNORNEY?
YES NO (circle) Attorney's name:

Attorney Address & Phone	IS THERE LITIGATION? Yes No Maybe

Mark the areas of Pain Resulting from this accident on the figure below:



PATIENT CONDITION

Type of pain (circle): Sharp Dull Throbbing Numbness Aching Shooting
Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your (circle any): Work Sleep Recreation Daily Routine

Activities or movements that are painful to perform (circle any): Sitting Standing Walking Bending Lying Down

HEALTH HISTORY

What treatments have you already received for your condition? (circle any) Medications Surgery Physical Therapy
Chiropractic None Other: _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of last: Physical Exam: _____ Spinal X-Ray: _____ Blood Test: _____
Spinal Exam: _____ Chest X-Ray: _____ Urine Test: _____
Dental X-Ray: _____ MRI ,CT-Scan, Bone Scan: _____ Mammogram: _____

Please circle " Y" for YES or a "N" for NO to indicate if you have had any of the following:

AIDS/HIV	Y	N	Fractures	Y	N	Parkinson's Disease	Y	N	Other (please list)	
Alcoholism	Y	N	Glaucoma	Y	N	Pinched Nerve	Y	N		
Allergies	Y	N	Goiter	Y	N	Pneumonia	Y	N		
Anemia	Y	N	Gonorrhea	Y	N	Polio	Y	N		
Anorexia	Y	N	Gout	Y	N	Prostate Problem	Y	N		
Appendicitis	Y	N	Heart Disease	Y	N	Psyciatric Care	Y	N		
Arthritis	Y	N	Hepatitis	Y	N	Rheumatoid Arthritus	Y	N		
Asthma	Y	N	Hernia	Y	N	Rheumatic Fever	Y	N		
Bleeding			Herniated Disk	Y	N	Scarlet Fever	Y	N		
Disorder	Y	N	Herpes	Y	N	Stroke	Y	N		
Breast Lump	Y	N	High Cholesterol	Y	N	Suicide Attempt	Y	N		
Bronchitis	Y	N	Measles	Y	N	Thyroid Problem	Y	N		
Bulimia	Y	N	High Blood			Tonsilitis	Y	N		
Cancer	Y	N	Pressure	Y	N	Tuberculosis	Y	N		
Cataracts	Y	N	Migraine Headaches	Y	N	Tumor, Growth	Y	N		
Chemical			Miscarriage	Y	N	Typhoid Fever	Y	N		
Dependency	Y	N	Multiple Sclerosis	Y	N	Ulcers	Y	N		
Chicken Pox	Y	N	Mumps	Y	N	Vaginal Infection	Y	N		
Diabetes	Y	N	Osteoporosis	Y	N	Venereal Disease	Y	N		
Emphysema	Y	N	Pacemaker	Y	N	Whooping Cough	Y	N		
Epilepsy	Y	N								

Exercise

None **(circle)**
Moderate
Daily
Heavy

WORK ACTIVITY

Sitting **(circle)**
Standing
Light Labor
Heavy Labor

Habits

Smoking Packs/Day _____
Alcohol Drinks/Week _____
Coffee/Caffeine Drinks Cups/Day _____
High Stress Level Reason _____

Females

Are you Pregnant?
Yes No
Due Date _____

Injuries / Surgeries	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications	Allergies	Vitamins/Herbs/Minerals

General Information

Employee: _____ Today's Date: _____

Social Security#: _____ Accident Date: _____

Job Description _____

Employer Name: _____

Contact Person: _____ Employer Phone: _____

Employer Address: _____

Street Address City State Zip

Assignment and Release

It is to be understood that the patient is 100% responsible for all services rendered. In the event that any service is not allowed and considered for payment by the work comp or personal injury insurance, the patient agrees to provide a standard health insurance plan; the patient is then responsible for any copays and deductibles as they are incurred. If the health insurance denies payment or indicates no coverage, the patient is then responsible to make payment immediately for all services not covered.

Please note that if services result in a lawsuit and payment is delayed due to this matter, our office will require a Letter of Protection or Lien from your attorney to await payment at time of settle, only if you remain an active patient.

The below signature acknowledges that I have read the above statement and understand the policy and financial responsibility. I agree to allow a release of any and all medical records to my health insurance, if requested, in order to insure prompt payment on the medical claim. I also authorize direct assignment of payment for all professional services to be paid by my employer and/or health insurance attorney to Pank Chiropractic located at 36321 Main Street, PO Box 486, Whitehall, WI 54773, and realize that any balance after my insurance will be promptly paid.

_____

Patient Signature **Date**

_____

Patient Name

**** FOR OFFICE USE ONLY ****

W/C Carrier (Name and Address)

_____

_____

_____

Phone#: _____

Claim#: _____

Adjuster: _____

Utilization Review Agent

_____

_____

_____

Phone#: _____

Fax#: _____

Nurse: _____

Date Verified: _____

Staff Member: _____

Spoke With: _____

Updated 02/10/2023