WORKERS' COMPENSATION QUESTIONNAIRE

PATIENT INFORMATION:

Name ______________________ Social Security # ______________
Address ______________________ City ______________
State ________ Zip ________ Age ________ Birthdate ___/___/___ Marital Status S M D
Home Phone ________ Work Phone ________ Referred by ______________
Name of Employer ______________________ Address ______________
Spouse's Name ______________________ Social Security # ______________
Birthdate ___/___/___ Name of Employer ______________________
Address ______________________ Work Phone ______________

INSURANCE INFORMATION:

Do you have health insurance? ☐ Yes ☐ No If Yes,
Name of Company ______________________ Policy # ______________
Have you retained an attorney? ☐ Yes ☐ No ☐ Litigation? ☐ Yes ☐ No
If yes, name & address ______________________

ACCIDENT INFORMATION:

Give time and date accident occurred ______________ ☐ AM ☐ PM ________ 19 ____
Were you knocked unconscious? ☐ Yes ☐ No If so, how long? ______________
Please explain in detail how your accident happened ______________________
____
____
____
Did you feel pain immediately after the accident? ________ Where? ______________
Did you return to work? ☐ Yes ☐ No If so, date returned ______________
Did you consult a doctor? ☐ Yes ☐ No If so, give doctor's name ______________
______________ ☐ D.O. ☐ M.D. ☐ D.C. ☐ D.D.S.
Doctor's diagnosis ______________________
What treatment 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
Give name of doctor who treated this injury before ______________________
Has any one recommended surgery? ☐ Yes ☐ No
Do any other diseases or accidents affect your employment? ☐ Yes ☐ No
Explain ______________________
At your work, do you have to favor any part of your body? ☐ Yes ☐ No
Explain ______________________
Have you beeen disabled? ☐ Yes ☐ Partially ☐ Totally ☐ No
Do you have a history of absenteeism caused from accidents on the job?
☐ Yes ☐ No Explain ______________________
Have you ever had a worker's compensation claim before? ☐ Yes ☐ No
Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No
Since this injury are your symptoms ☐ Improving? ☐ Getting Worse? ☐ The Same?
How do you feel in the a.m.? ☐ Better ☐ Worse ☐ No difference
How do you feel in the p.m.? ☐ Better ☐ Worse ☐ No difference
Are your work activities restricted as a result of this accident? ☐ Yes ☐ No
When did you first notice this condition? ______________________
Any radiation of pain into an extremity? ________ Where ______________
Does any position relieve your condition? ________ If yes, what ______________
Location of pain ______________ Frequency of pain ______________
Duration of pain ______________________
List medication taken for this condition ______________________

Who recommended this medication? ______________________________

Please mark your areas of pain on the figures below.

Check symptoms you have noticed since the accident:

- ☐ Headache
- ☐ Neck Pain
- ☐ Neck Stiffness
- ☐ Insomnia
- ☐ Tension
- ☐ Irritability
- ☐ Loss of taste
- ☐ Loss of smell
- ☐ Loss of memory
- ☐ Diarrhea
- ☐ Neuritis
- ☐ Anxiety
- ☐ Fainting
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Constipation
- ☐ Depression
- ☐ Eye Strain
- ☐ Nausea, Vomiting
- ☐ Face flushed
- ☐ Palpitation
- ☐ Tremors
- ☐ Pallor
- ☐ Sinus Trouble
- ☐ Mental Dullness
- ☐ Extreme Nervousness
- ☐ Extreme Fatigue
- ☐ Pain behind eyes
- ☐ Double vision
- ☐ Digestive Disorders
- ☐ Equilibrium Disorders
- ☐ Head seems too heavy

- ☐ Shortness of breath
- ☐ Excessive perspiration
- ☐ Upper back (pain, stiffness)
- ☐ Mid-back (pain, stiffness)
- ☐ Low back (pain, stiffness)
- ☐ Swelling — where ______________
- ☐ Feet cold; hands cold
- ☐ Restriction of neck motion
- ☐ Buzzing/ringing in ears
- ☐ Eyes sensitive to light, loss of focus
- ☐ Head and shoulders feel tired/heavy
- ☐ Pins and needles in arms/legs
- ☐ Numbness in fingers/arms/legs
- ☐ Difficulty in prolonged riding in car
- ☐ Difficulty in excessive standing/walking/bending
- ☐ Neck/low back pain/stiffness upon rising
- ☐ Pain radiating into (right/left/both) arm/leg
- ☐ Difficulty in excessive lifting
- ☐ Difficulty in rising to walk after sitting
- ☐ Difficulty in excessive twisting/turning
- ☐ Other

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment when services are rendered. A late charge of 1.5% per month (but not to exceed lawful maximum) may be added to any amount sixty (60) days in arrears if not received prior to the next billing date. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: ______________________________ Date ______________

Patient's Drivers License # ______________________________

Guardian Or Spouse's Signature: ______________________________

Doctor's Signature: ______________________________