

# 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.

Name \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_ Who referred you to our office? \_\_\_\_\_

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

Social Sec. # \_\_\_\_\_ Business Phone \_\_\_\_\_ Company Name \_\_\_\_\_ Location \_\_\_\_\_

Spouse's First Name \_\_\_\_\_ Spouse's Soc. Sec. # \_\_\_\_\_ Spouse's Employer \_\_\_\_\_ Location \_\_\_\_\_

Please explain in detail how your accident happened \_\_\_\_\_

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Have you retained an attorney?  Yes  No Litigation?  Yes  No  Maybe

If so, name and address \_\_\_\_\_

Give time and date present injury occurred \_\_\_\_\_  AM  PM \_\_\_\_\_ 19 \_\_\_\_\_

Where did you feel pain immediately after the accident? \_\_\_\_\_

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

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 treatments 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

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 so, explain \_\_\_\_\_

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

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

Since this injury are your symptoms  improving?  getting worse?  the same?

**HEALTH QUESTIONNAIRE:**

Please indicate for each of the questions below your experience by use of the following codes: 1-never had; 2-previously had; 3-presently have.

**MUSCULO-SKELETAL SYSTEM**

- Low back problems
- Pain between shoulders
- Neck problems
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Ruptures
- Broken bones

**GENITO-URINARY SYSTEM**

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

**FEMALE**

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on breast
- Are you pregnant?
- Yes  No

**GASTRO-INTESTINAL SYSTEM**

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting food
- Vomiting blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

**CARDIO-VASCULAR-RESPIRATORY SYSTEM**

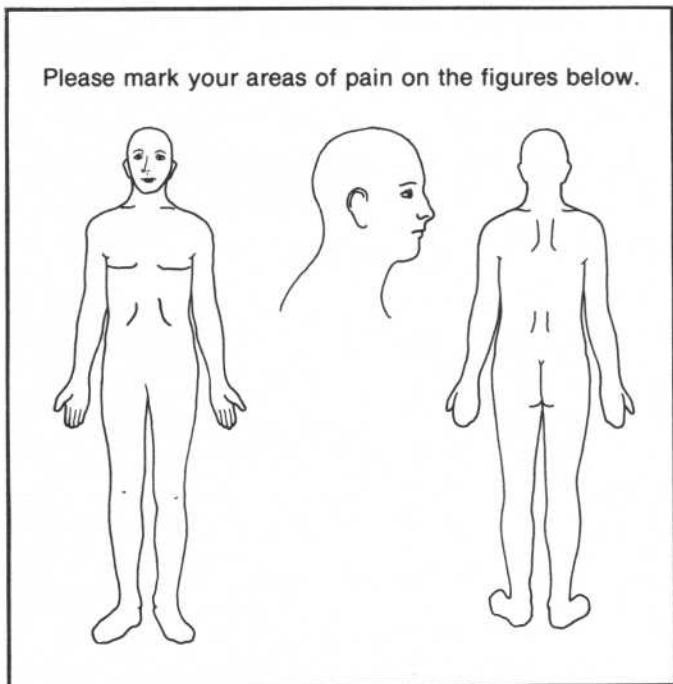
- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

**EYE, EAR, NOSE, AND THROAT**

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Hearing loss
- Ear discharge
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing thru nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech

**NERVOUS SYSTEM**

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression



\_\_\_\_\_  
Patient's Signature

..... DO NOT WRITE BELOW THIS LINE .....

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Patient accepted?  Yes  No Doctor's Signature \_\_\_\_\_

# VERIFICATION OF INSURANCE COVERAGE

WORKERS' COMPENSATION       AUTO ACCIDENT       PERSONAL INJURY

Date \_\_\_\_\_

Insured \_\_\_\_\_ Telephone \_\_\_\_\_

Insured's Address \_\_\_\_\_

Patient \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

SS# \_\_\_\_\_ Adjustor: \_\_\_\_\_

Claim #: \_\_\_\_\_ Adjustor's Phone: \_\_\_\_\_

Insurance Company \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Injury/Accident Date \_\_\_\_\_ Time \_\_\_\_\_  AM  PM

Insured's Employer \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## WORKERS COMPENSATION

Employer's Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Has injury been reported?  Yes  No      To Whom? \_\_\_\_\_

## AUTO ACCIDENT

Has the accident been reported to the insurance company?  Yes  No

Was a police report made?  Yes  No

Name of Agent \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

## PERSONAL INJURY

Has injury been reported to insurance company?  Yes  No

## ATTORNEY INFORMATION

Has an attorney been retained for any of the above?  Yes  No

Name of attorney \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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