WORKERS COMPENSATION QUESTIONNAIRE

This information confidential. We need information because we care enough to want to know. 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. Please be as neat and accurate as possible. Thank you.

Name_____ Sex: M or F DateBirth_____ Phone#_____

Address_____ City/State/Zip_____

Occupation_____ Who referred you to our office? _____

Company Name/Address_____

Company Phone #_____ Date of Accident:_____

Please explain in detail how your accident happened:_____

_____

_____

_____

Time of accident:_____ am pm Did you return to work? Yes No When?_____

Any other Doctors consulted? Any Diagnostics? List Names/Addresses/Dates:_____

_____

_____

Diagnosis & Treatments received:_____

_____

Have you been injured in this area before? Yes No When?_____

Did you lose time from worth then? Yes No If yes, Doctor's name(s)_____

Any other Diseases or Accidents affect your employment? Yes No Explain:_____

_____

In your work do you have to FAVOR any part of your body? Yes No Explain: _____

_____

Do you have history of absenteeism caused from accidents on job? Yes No

Have you ever had a Workmens Compensation claim before? Yes No

Before this 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

Have you retained an attorney: Yes No Litigation: Yes No

Attorney Name/Address:_____

_____
Patient Signature/Date

Patient Accepted? Yes No _____
Doctor's Signature