PI/WC Questionnaire

CHIROPRACTIC FIRST
3195 S. Bascom Ave. • Campbell, CA 95008 • 408-559-1662 • F: 408-559-0946

Dear patient: Date:_____________

We need this information answered completely to help us assess your need for care. If we did not sincerely believe your condition will respond to chiropractic care, we will not accept you as a patient. Thank you.

General Information:

Name_______________________________ Sex(M/F) Marital Status(M/S/D/W) D.O.B __/__/___Phone(____)____________

Address____________________________ City____________ State______ Zip________

Occupation_____________________ Work Phone _____________ OK to call? Yes/No

Nature of Accident:

1. What was the time and date of this present injury?___________________________
2. Please explain in detail how your accident happened (please include location, equipment and conditions.)____
____
____
____
____
____
____
3. Did you come in contact with any objects? Yes No
If yes, what objects?____
4. What parts of your body came in contact with the above objects?__________________
____
5. Where did you feel the pain or unusual feeling immediately after the accident? (Please show the areas on the pain chart also.)____
____
____
____
6. Were you unconscious as a result of the injury? Yes No If so, how long?__________
7. Were you bleeding as a result of the injury?____________________________________
8. Did you consult any other doctor?________________________________ DC MD DO
9. Describe the doctor's diagnosis____
10. What treatment did you receive?____
11. Are you still under a doctor's care?________ If yes, please explain_______________
____

(over)

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Past History

1. Have you ever injured this area before?_________ If yes, when?__________________
2. If injured before, did you lose time from work?________________________________
3. Have you been involved in any previous accidents of any kind (personal injury, automobile accident or worker's compensation)?______ If yes, please explain dates and details____
____
____
4. Have you been treated previously by a chiropractor?______ If yes, explain _________
____
____

Present Information/Disability:

1. Have you returned to work?_______ If yes, date returned to work________________
2. Your job description:____
3. Do you favor any part of your body in your work?______ If yes, please explain _____
____
4. Are your work activities restricted as a result of this accident?_____ If yes, please explain____
5. Since this injury, are your symptoms: improving____, getting worse _____, same ____
6. Do any other diseases affect your employment?____ If yes, please explain__________
____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

____________________________	____________________________
Patient Signature	Date
____________________________	____________________________
Doctor's Signature (upon review)	Date