

# 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.

## PERSONAL INFORMATION

Name \_\_\_\_\_

Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Date of Birth \_\_\_\_\_

Home Phone \_\_\_\_\_

Address \_\_\_\_\_

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

Occupation \_\_\_\_\_

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

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

Social Security # \_\_\_\_\_

Business Phone \_\_\_\_\_

Company Name \_\_\_\_\_

Location \_\_\_\_\_

## SPOUSE'S INFORMATION

Name \_\_\_\_\_

Social Security # \_\_\_\_\_

Employer \_\_\_\_\_

Location \_\_\_\_\_

**Your  
practice name,  
phone number,  
address and  
logo here**

## ACCIDENT INFORMATION/DETAILS

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Time and date present injury occurred \_\_\_\_\_ am / pm \_\_\_\_\_

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

\_\_\_\_\_

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

Have you ever injured this area before? Yes No  
If so, date returned to work \_\_\_\_\_

If injured before, did you lose time from work? Yes No

Before the injury, were you capable of  
working on an equal basis with others your age? Yes No

Have you tried any home remedies for your condition such as aspirin,  
heating pad, ice packs, etc.? \_\_\_\_\_

What aggravates your condition? \_\_\_\_\_  
(For example: walking, sitting, bending, etc.)

Is there any position that you can get  
into that makes your condition better? \_\_\_\_\_

Does your condition interfere with your work? Yes No  
If so, how? \_\_\_\_\_

Since this injury, are your symptoms:  
Getting better Worse About the same

List all medications you are now taking \_\_\_\_\_

\_\_\_\_\_

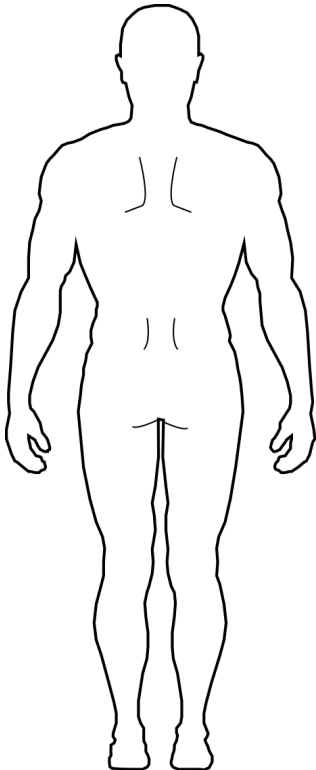
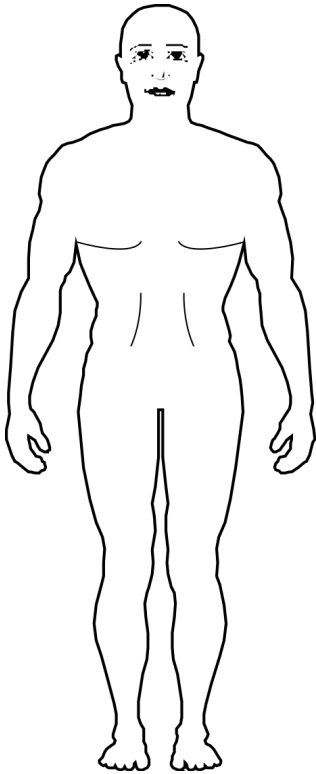
List any other comments relative to this accident \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW.**



## ACCIDENT INFORMATION/DETAILS CONTINUED

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

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

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 treatment did you receive? \_\_\_\_\_  
\_\_\_\_\_

Do any other diseases or accidents affect your employment?    Yes    No  
If so, please explain \_\_\_\_\_

If you lost time from work with injuries prior to this injury, give name of doctor(s) consulted \_\_\_\_\_  
\_\_\_\_\_

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

List all previous surgeries \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List secondary complaints not directly related to this accident \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_