Worker's Compensation Questionaire

IN ORDER FOR US TO BEST SERVE YOU, WE MUST, NATURALLY, HAVE ALL AVAILABLE INFORMATION REGARDING YOUR PRESENT HEALTH. WOULD YOU PLEASE COMPLETE THE FOLLOWING:

Patient Information

Date: _____

Name: _____ Age:_____ Date of Birth: _____

Social Security No.: _____-____-_____ Email: _____

Address: _____ City/State/Zip: _____

Preferred Phone # _____ Cell / Home Work Phone: _____

May we contact you via Email? Yes / No Text? Yes / No

Marital Status: Married / Single / Divorced / Widowed Sex: Male / Female Are you pregnant? Yes / No

Employer:_____

Spouses Name:_____ Spouses Employer: _____

Children(s) Ages:_____

Emergency Contact: _____

Relationship:_____ Phone: _____

Who or What Source Referred You:_____

Ethnicity: Hispanic or Latino/Other Preferred Language: _____

Race: Asian / African Am. Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White

Smoking Status: Every Day / Some Days / Former / Never

Education : High School / Some College /College Grad / Graduate School

---

Primary Care Physician: _____ Doctor's Phone: _____

May we communicate with your Primary Care Physician about your care in our office? Yes / No

Who is responsible for payment? Self / Spouse / Other Ins. Company: _____

If Other, please explain: _____

Give date and time present injury occurred ____/____/____ _____ AM PM

Please explain in detail how your accident happened?

_____

_____

_____

Did you report Injury to Employer Yes | No

Where did you feel pain after the accident? Neck | Upper-Back | Mid-Back | Low Back | Other:_____

Did you return to work? Yes | No If so, date returned to work _____

Did you consult any other doctor? Yes | No

Did employer send you to any other doctor? Yes | No

Wills Chiropractic Clinic PC
416 Valley View Dr, Suite 1300 Scottsbluff, NE 69361

updated 4/20/20

CA_____DR_____

Worker's Compensation Questionaire

IN ORDER FOR US TO BEST SERVE YOU, WE MUST, NATURALLY, HAVE ALL AVAILABLE INFORMATION REGARDING YOUR PRESENT HEALTH. WOULD YOU PLEASE COMPLETE THE FOLLOWING:

If so, doctor's name_____ D.C. | M.D. | D.O. | P.A.

Doctor's Diagnosis_____

What treatment was given?_____

How often did you see the doctor?_____ How long did you see the doctor? _____

Did you lose time from work? Yes | No

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_____

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

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

Since the injury, are your symptoms Improving | Getting worse | the same

---

Have you retained an attorney? Yes | No Is Litigation Pending? Yes | No

Name, address & phone of attorney _____

Have You Noticed any Changes in Bodily Function [Urination, Defecation, Respiration, Digestion, Vision, Sexual, other] since the onset of your complaint? Yes / No Describe:_____

Had any diagnostic testing? X-rays / MRI / CT / Other: _____

Are you taking any medication Yes / No OTC/ Prescriptions _____

Allergies to Medications? Yes / No _____

Have you had any surgeries or broken any bones? Yes / No Please Explain: _____

Have you been diagnosed/treated for cancer? Yes / No Please Explain: _____

Have you had any new falls or accidents? Yes / No Date of fall or accident: _____

Please explain in detail how the fall or accident happened:_____

_____

Additional patient comments:_____

_____

_____

_____

_____

_____

Wills Chiropractic Clinic PC
416 Valley View Dr, Suite 1300 Scottsbluff, NE 69361

updated 4/20/20

CA_____DR_____

Worker's Compensation Questionaire

IN ORDER FOR US TO BEST SERVE YOU, WE MUST, NATURALLY, HAVE ALL AVAILABLE INFORMATION REGARDING YOUR PRESENT HEALTH. WOULD YOU PLEASE COMPLETE THE FOLLOWING:

Internal Use Only

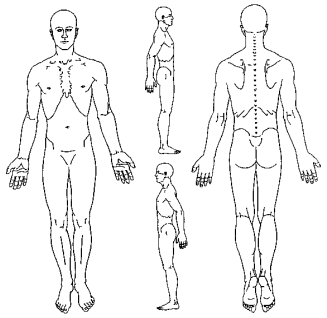
Last Visit: _____ **NP | New Incident | Re-Exam**

Patients Appearance/Mood: Distress | Mild | Moderate | Severe Nourished: Well | Obese | Morbid

Other_____

Additional Info: _____

_____



H	__	Hypoesthesia	T	__	Tenderness upon palpation
N	__	Numb			
P	__	Pain	S	__	Spasm

X-RAY ORDERED:

Cervical	Thoracic	Lumbar
3 Views	2 Views	2 Views
5 Views	4 Views	4 Views
7 Views	Flex / Ext	Flex / Ext
Oblique's		Oblique's
Flex/Ext		AP Spot

Right | Left
Hip | Knee | Ankle | Foot
Right | Left
Shoulder | Elbow | Wrist | Hand

VITALS:

HGT: _____

WGT: _____

BP: _____

Pulse: _____

TREATMENT:
Exam M A DJ X LLL

Wills Chiropractic Clinic PC
416 Valley View Dr, Suite 1300 Scottsbluff, NE 69361

updated 4/20/20

CA_____DR_____