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 _____

Wind Gap
Chiropractic Center

964 Chestnut Street
Easton, PA 18091

(610) 863-9220

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 _____

_____

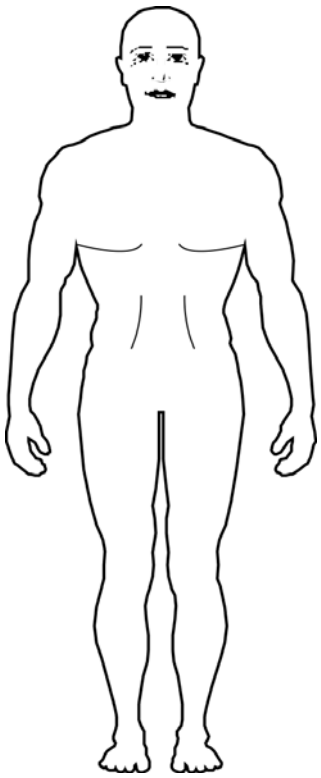
List any other comments relative to this accident _____

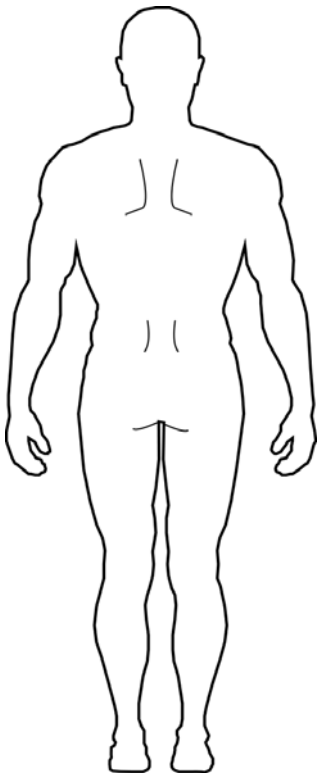
_____

_____

_____

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: _____