# Worker's Compensation Questionnaire

Date _____ Title: Mr. Mrs. Miss Ms. Dr. (circle one)
Last Name _____ First Name _____ Middle Initial _____
Address _____ City _____ State _____ Zip _____
Home Phone # _____ Work Phone # _____ Cell Phone # _____
E-mail Address _____
Social Security # _____ Age _____ Date of Birth _____ Sex: Male or Female
Height _____ Weight _____ Status: Married Single Widowed Divorced # of Children _____
Your occupation and a brief description of activities: _____
_____
Employer _____
Employers Address _____ City _____ State _____ Zip _____
Spouse's Name _____ Occupation _____ Employer _____
Nearest Relative Not Living with You _____ Phone # _____
Address _____ City _____ State _____ Zip _____
Person Responsible For This Account _____
How were you referred to this office? Friend/Relative, Name _____
Yellow Pages Newspaper TV Direct Mail Exam Card
Coupon Radio Courtesy Call Other _____
Have you seen a Chiropractor in the Past? Yes No Name _____

Did you report the injury to your supervisor or employer? Yes No
Did your company recommend care at our office? Yes No
Give time and date the injury occurred: _____
Please explain in detail how your accident happened: _____
_____
_____
Where did you feel pain immediately after the accident? _____
Did you require post-accident hospitalization? Yes No If so, where? _____
Did you consult any other doctor? Yes No
If so, Doctor's name: _____
Diagnosis: _____
What treatments did you receive? _____
Did you return to work? Yes No If so, what date? _____
Have you ever injured this area before? Yes No If so, when? _____
If injured before, did you lose time from work? Yes No
If you lost time from work with injuries prior to this injury, give name of Doctor (s) consulted: _____
_____

Check the symptoms you have noticed since the accident:

| | | | |
|---|---|---|---|
| ___ Headaches | ___ Pins & Needles in Legs | ___ Fatigue | ___ Face Flushed |
| ___ Neck Pain | ___ Pins & Needles in Arms | ___ Loss of Smell | ___ Neck Stiff |
| ___ Sleeping Problems | ___ Numbness in Fingers | ___ Loss of Taste | ___ Ringing in Ears |
| ___ Back Pain | ___ Numbness in Toes | ___ Diarrhea | ___ Buzzing in Ears |
| ___ Nervousness | ___ Shortness of Breath | ___ Feet Cold | ___ Loss of Balance |
| ___ Tension | ___ Lights Bother Eyes | ___ Hands Cold | ___ Fever |
| ___ Irritability | ___ Change in Vision | ___ Stomach Upset | ___ Dizziness |
| ___ Chest Pains | ___ Head Seems Too Heavy | ___ Constipation | ___ Loss of Memory |
| ___ Cold Sweats | ___ Change in Urination | ___ Depression | ___ Fainting |

Symptoms other than above: _____

_____

_____

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: _____

_____

Do you have a history of absenteeism caused from accidents on the job? Yes No
Have you ever had a Workman'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 this injury are your symptoms:
Improving _____ Getting Worse _____ Staying the same _____

Have you hired an attorney? Yes No

If so, name and address of Attorney: _____

_____

Comments or other important information you wish to express: _____

_____

_____

_____

_____

_____

_____