

Worker's Compensation Questionnaire

Please Print

Give complete answers to all questions. This information is confidential. Your input will help determine if chiropractic can help you.

Patient Information

Last Name		First	Middle	Today's Date		Case No.
Address			City		State	Zip
Social Security	Age	Birth Date	Sex	Marital Status	No. of Children	Home Phone
Employer		Address				Business Phone
Occupation		Who referred you to us			Address	

Accident Information

Give all the details on how your accident occurred

	Yes	No
Have you retained an attorney?	☐	☐
Is there litigation?	☐	☐
After the accident did you return to work?	☐	☐
Did you consult any other doctor?	☐	☐
Have you ever injured this same area before?	☐	☐
If injured before, did you lose work time?	☐	☐
Do any other diseases or accidents affect your work performance?	☐	☐
When working, do you have to favor any part of your body?	☐	☐
Do you have a history of absenteeism because of accidents on the job?	☐	☐
Have you had a worker's compensation claim before?	☐	☐
Before the injury, were you capable of working on an equal basis with others your age?	☐	☐
Are your work activities restricted as a result of this accident?	☐	☐

If an attorney is retained, give full name and address:					Phone
Date and time injury occurred	Month:	Day:	Year:	Time:	☐ AM ☐ PM
In what exact area did you feel pain immediately after the accident?					
If you returned to work, what was the date Mo. Date Yr.					
If you consulted another doctor give his name and degree					
What was the doctors diagnosis?					
What treatment, if any, did you receive					
If you lost time from work with injuries prior to this injury, give the names of the doctor(s) consulted					
If you have other conditions that affect your work performance, explain them					
If you favor any body part while working, explain what is involved					

Since this injury, are your symptoms: ☐ The same ☐ Better ☐ Worse

Health Survey

Please rate each condition below with one of the appropriate following symbols X presently have ✓ previously had — never had

Gastrointestinal

Cardiovascular

Musculoskeletal

Genitourinary

- _____ Poor appetite
- _____ Excessive hunger
- _____ Difficult chewing
- _____ Difficult swallowing
- _____ Excessive thirst
- _____ Nausea
- _____ Vomiting food
- _____ Vomiting blood
- _____ Abdominal pain
- _____ Diarrhea
- _____ Constipation
- _____ Black stool
- _____ Bloody stool
- _____ Hemorrhoids
- _____ Liver trouble
- _____ Gall bladder problems
- _____ Weight trouble

Nervous System

- _____ Numbness
- _____ Loss of feeling
- _____ Paralysis
- _____ Dizziness
- _____ Fainting
- _____ Headaches
- _____ Muscle jerking
- _____ Convulsions
- _____ Forgetfulness
- _____ Confusion
- _____ Depression

- _____ Chest pain
- _____ Pain over heart
- _____ Difficult breathing
- _____ Persistent cough
- _____ Coughing phlegm
- _____ Coughing blood
- _____ Rapid heartbeat
- _____ Blood pressure problems
- _____ Heart problems
- _____ Lung problems
- _____ Varicose veins

Eye, Ear, Nose and Throat

- _____ Eye strain
- _____ Eye inflammation
- _____ Vision problems
- _____ Ear pain
- _____ Ear noises
- _____ Hearing loss
- _____ Ear discharge
- _____ Nose pain
- _____ Nose bleeding
- _____ Nose discharge
- _____ Difficult breathing thru nose
- _____ Sore gums
- _____ Dental problems
- _____ Sore mouth
- _____ Sore throat
- _____ Hoarseness
- _____ Difficult speech

- _____ Low back problems
- _____ Pain between shoulders
- _____ Neck problems
- _____ Arm problems
- _____ Leg problems
- _____ Swollen joints
- _____ Painful joints
- _____ Stiff joints
- _____ Sore muscles
- _____ Weak muscles
- _____ Walking problems
- _____ Ruptures
- _____ Broken bones

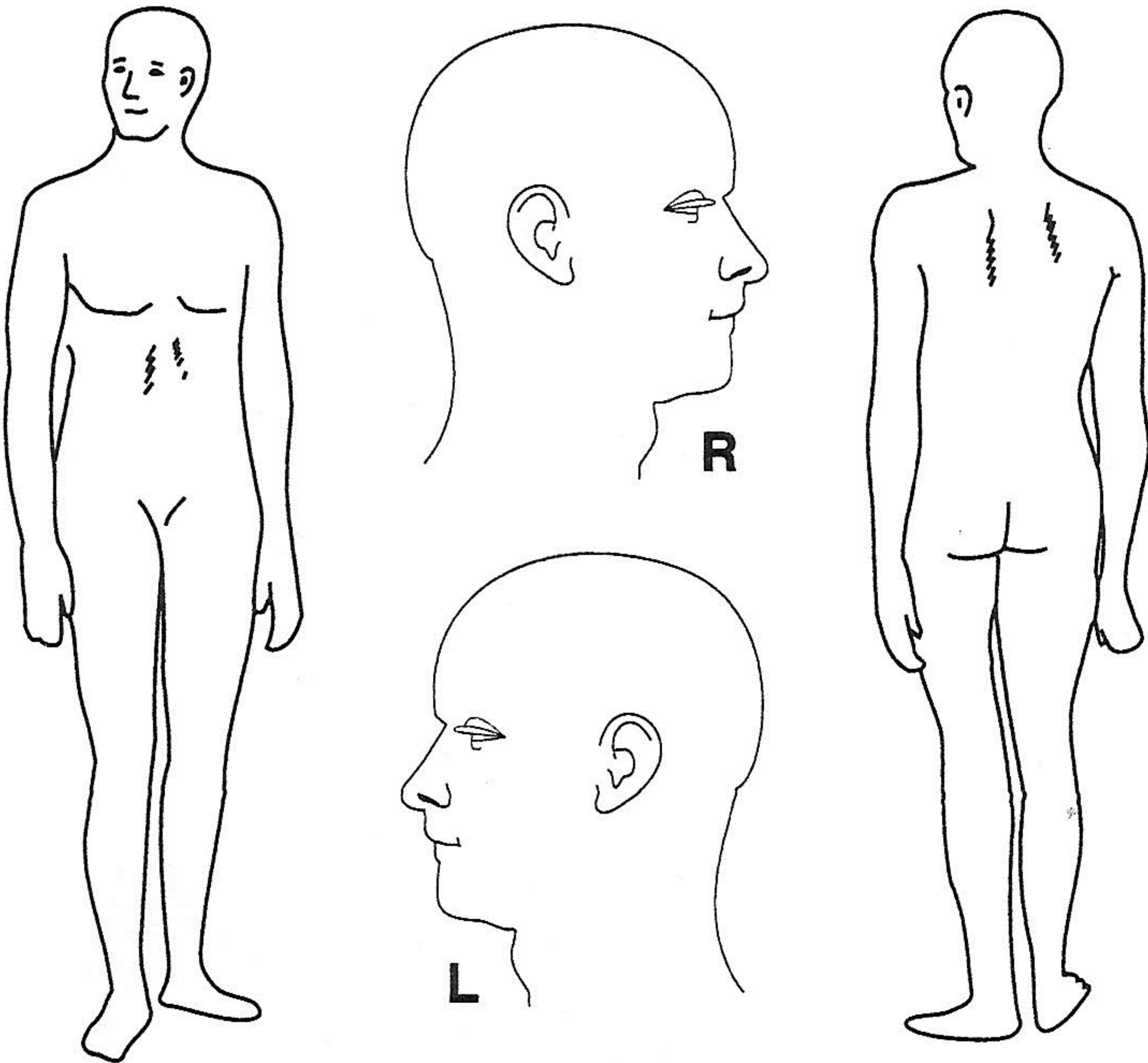
- _____ Bladder trouble
- _____ Excessive urination
- _____ Scanty urination
- _____ Painful urination
- _____ Discolored urine

Female

- _____ Vaginal discharge
- _____ Vaginal bleeding
- _____ Vaginal pain
- _____ Breast pain
- _____ Lumps on breast

Are you pregnant
_____ Yes _____ No

Mark areas of pain resulting from this accident on figures below



Patient's signature (If a minor, parent or guardian's signature) _____ Date _____

Office Use (Do not write below here)

Doctor's signature _____ Date _____