



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.

Name _____ Sex _____ Marital Status _____ Date Of Birth _____ Home Phone _____

Address _____ City _____ State _____ Zip Code _____

Occupation _____ Who referred you to our office? _____

Social Security Number: _____ Employer Phone Number: _____

Employer _____ Address _____ City _____ State _____ Zip Code _____

Please explain in detail how your accident happened _____

Have you retained an attorney? Yes No Litigation? Yes No Maybe
If so, name and address _____

Give time and date present injury occurred _____ AM _____ PM _____ 19 _____

Where did you feel pain immediately after the accident? _____

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

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 treatments did you receive? _____

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 of doctors consulted _____

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 Workers 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? The same?

HEALTH QUESTIONNAIRE:

Please indicate for each of the questions below your experience by use of the following codes: 1-never had, 2-previously had, 3-presently have

MUSCULO-SKELETAL SYSTEM

- 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

GENITO-URINARY SYSTEM

- 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

GASTRO-INTESTINAL SYSTEM

- 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

CARDIO-VASCULAR-RESPIRATORY SYSTEM

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

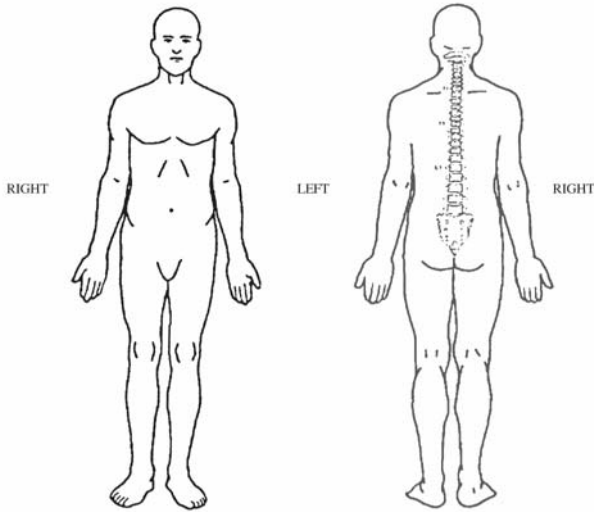
EYE, EAR, NOSE & THROAT

- 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

NERVOUS SYSTEM

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

Please mark your areas of pain on the figures below.



Patient's Signature

-----DO NOT WRITE BELOW THIS LINE-----

Patient accepted? Yes No Doctor's Signature_____