Worker's 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_____
Address_____ City_____ State_____ Zip_____
Occupation_____ Who referred you to our office_____
S.S.#_____Work Phone_____ Company Name_____
Address_____ Name of supervisor_____
First Name of Spouse_____ Spouse S.S.#_____
Spouse Employer_____Location_____

Please explain in detail how your accident happened_____
_____
_____
_____

Have you retained an attorney? ___Yes___No Litigation? ___Yes ___No Maybe_____
If so, Name and Phone number_____
Give time and date present injury occurred_____A.M.__ P.M.__20____
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 or 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 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 this injury are your symptoms ___improving? ___getting worse?___the same?

Health Questionnaire:

Please place a check next to the symptoms you 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-UNIARY 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
___Diarrhea
___Constipation
___Black stool
___Hemorrhoids
___Liver trouble
___Gall bladder
___Weight trouble

NERVOUS SYSTEMS

___Numbness
___Loss of feeling
___Paralysis
___Dizziness
___Fainting
___Headaches
___Muscle jerking
___Convulsions
___Forgetfulness
___Confusion
___Depression

CARDIO-VASCULAR-RESPIRATORY SYSTEM

___Chest pain
___Pain over heart
___Difficult breathing
___Persistent cough
___Coughing phlegm
___Coughing blood
___Rapid hearbeat
___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

_____

PATIENT'S SIGNATURE **DATE**

DO NOT WRITE BELOW THIS LINE