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 _____

Occupation _____ Who referred you to our office? _____
(Indicate if child, student, housewife, unemployed, retired)

Social Sec. # _____ Business Phone _____ Company Name _____ Location _____

Spouse's First Name _____ Spouse's Soc. Sec. # _____ Spouse's 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 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 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 Workmen'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 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

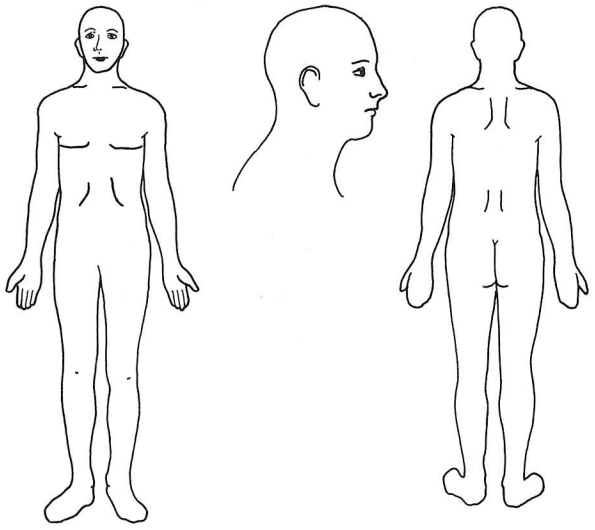
_____ Bladder trouble
_____ Excessive urination
_____ Scanty urination
_____ Painful urination
_____ Discolored urine

FEMALE

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

Are you pregnant?
_____ Yes _____ No

Please mark your areas of pain on the figures below.



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

NERVOUS SYSTEM

_____ 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 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

_____
Patient's Signature

DO NOT WRITE BELOW THIS LINE

Patient accepted? ☐ Yes ☐ No Doctor's Signature _____