WORKER'S COMPENSATION QUESTIONAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Date _____

Patient _____ No. _____

Sex _____ Marital Status _____ Date of Birth _____ Home Phone _____

Address _____ City _____ State_____ Zip _____

Occupation _____

Type of work you do (labor) _____

Who refered you to our office? _____

Social Sec. #_____ Business Phone_____ Company Name_____

Company Address _____

Please explain in detail how your injury occurred? _____

_____

_____

_____

_____

Give time and date present injury occurred _____ ❑ AM ❑ PM ____/____/____

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

Did employer send you to any other doctor? ❑ Yes ❑ No

If so, give doctor's name _____ ❑ D.C., ❑ M.D., ❑ D.O., ❑ D.D.S. _____

Doctor's Diagnosis _____

Did you lose time from work? ❑ Yes ❑ No

What medications are you presently taking? _____

_____

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 _____

_____

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 the injury, are your symptoms ❑ Improving? ❑ Getting worse? ❑ The same?

Have you retained an attorney? ❑ Yes ❑ No Litigation? ❑ Yes ❑ No

If so, name, address & phone # _____

PLEASE DO NOT WRITE BELOW THIS LINE

This injury was verified by _____ on _____

Name of supervisor who verified the injury:

_____ Time of call _____