Workers' Compensation Questionnaire

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 _____

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

Currently out of work due to injury ☐ Yes ☐ No If yes, absent from _____ until _____

Date returned to work _____

Please explain in detail how your accident happened _____

_____

_____

_____

_____

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? _____ Treatment helpful? ☐ Yes ☐ No

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 _____

_____

Have you retained an attorney? ☐ Yes ☐ No

If so, name and address _____

ADDITIONAL HEALTH INFORMATION

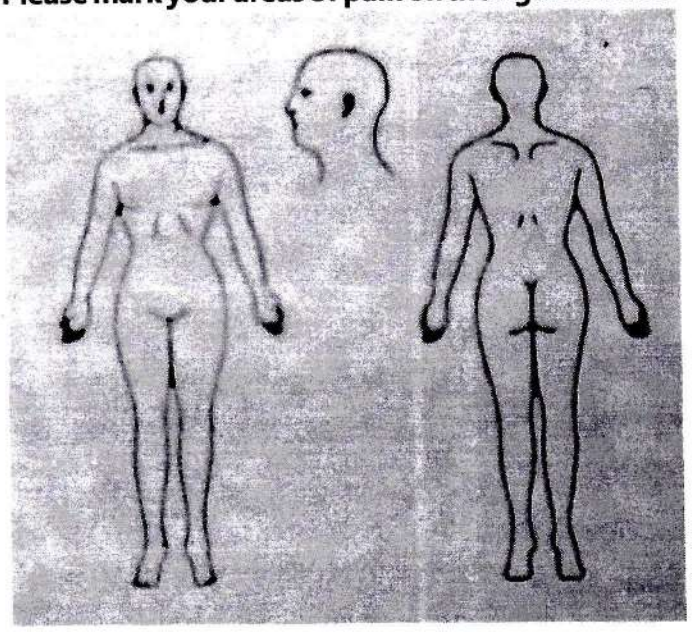
Drugs you now take _____

List surgical operations _____

Other health problems within your family? _____

Thank you for completing the above essential information.
PLEASE TURN THIS FORM OVER, COMPLETE AND SIGN WHERE INDICATED.

Please mark your areas of pain on the figures below



Have You Ever Suffered From:

- ☐ Dizziness
- ☐ Fainting
- ☐ Blurred/Fading Vision
- ☐ Arthritis
- ☐ Allergies
- ☐ Asthma
- ☐ Heart Trouble
- ☐ Diabetes
- ☐ Colon Disorders
- ☐ Nervousness
- ☐ High Blood Pressure
- ☐ Fractures
- ☐ Polio
- ☐ Pneumonia
- ☐ TB
- ☐ Cancer
- ☐ Migraine
- ☐ Bone/Joint Disorders
- ☐ Rashes/Hives
- ☐ Hepatitis
- ☐ Epilepsy
- ☐ Meningitis
- ☐ Gall/Kidney Stones
- ☐ Anemia
- ☐ Other

INSURANCE INFORMATION

It is the patient's responsibility to file a claim with their insurance carrier, and submit necessary paperwork to the insurance company as requested. We will submit all claims directly to the insurer and await their payment; but, if your case is denied, you or your private medical insurance company may be fully or partially responsible for all expenses incurred.

I authorize this chiropractic office to release any information concerning my care, which is necessary for claims processing, to the appropriate insurance companies and/or attorneys that may be involved with my case.

Signature_____ Date_____