Worker's Compensation Questionnaire

All information in this box is REQUIRED.
If any information is missing, we may reschedule your appointment until you obtain all information needed to bill worker's comp for your treatment. **We are unable to treat patients who do not have claim numbers.**

Patient's Name:_____ Today's Date:_____

Date of Injury: _____/_____/_____ Worker's Comp Insurance Carrier: _____

Carrier Case Number: _____

Claims Adjuster's Name: _____

Claims Adjuster's Phone Number: _____

Employer at the time of Injury: _____ May we contact your employer? □ Yes □ No

Job title/description at the time of Injury: _____

Work Status

Have you missed any work due to your injury? □ Yes □ No

Are you currently out of work due to this accident? □ Yes □ No

Date you were taken out of work: _____/_____/_____

Doctor who took you out of work: _____

Any light duty restrictions (if applicable): _____

What percentage of disability? (If known) _____

Date you returned to work (if applicable): _____/_____/_____

Nature of Work-Related Accident:

Please explain in detail how your accident happened. Include location, condition of area, and equipment involved, if any.

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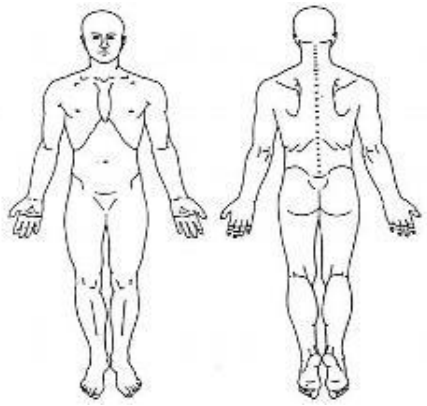
Where did you feel pain or unusual feeling immediately after the accident? (Mark the areas on the diagram and describe below)



Were you unconscious as a result of the injury? □ Yes □ No If Yes, for how long? _____

Were you bleeding as a result of the injury? □ Yes □ No If Yes, where? _____

Did you leave the work area after the accident to seek medical attention? □ Yes □ No

Have you consulted any other doctor? □ Yes □ No

Doctor's Name _____ Circle Type: DC / MD / DO

Describe the doctor's diagnosis _____

What treatment did you receive? _____

Are you still under another doctor's care? □ Yes □ No

If Yes, explain: _____

Past History:

Have you ever injured this area before? □ Yes □ No

If you lost time from work with past injuries (excluding this current injury), please list treating doctors:

_____

Have you been involved in any previous accidents of any kind (personal injury, automobile accident or workers' compensation)? □ Yes □ No If yes explain _____

I certify that I have read, or had read to me, and understand the above information. To the best of my knowledge the above questions have been answered accurately and honestly. I understand that providing incorrect information is not only illegal but can affect my treatment at this office.

_____ ____/____/____

Signature of Patient Date