Chiropractic Associates, Inc.

WORKERS' COMPENSATION QUESTIONNAIRE

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 to determine if chiropractic care 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: _____ Present Occupation _____

Occupation at Time of Injury: _____ Employer at Time of Injury: _____

Address of Employer: _____

Time and Date of Injury: _____

If this is an old claim, how long have you been with your present employer? _____

Explain in detail how your accident happened: _____

_____

Have you retained an attorney? YES NO Litigation? YES NO MAYBE

If so, name and address of attorney: _____

Where did you feel pain immediately after the accident happened? _____

Did you return to work: YES NO Date returned to work: _____

List dates/period of disability: From _____ To _____ From _____ To _____

Did you consult any other doctor? YES NO Doctor's name: _____

Doctor's diagnosis: _____

_____

List treatments you received: _____

_____

Have you injured this area before? YES NO If so, when? _____

If injured before, did you lose time from work? YES NO

If lost time from work, give name of doctor consulted: _____

Do any other accidents or diseases affect your employment? YES NO Explain: _____

_____

In your work, do you have to favor any part of your body? YES NO Explain: _____

_____

Do you have a history of absenteeism caused from accidents on the job? YES NO

Have you ever had a workers' compensation claim before? YES NO Explain and list claim numbers and dates of injury: _____

_____

Before the injury, were you capable of working on an equal basis with others your age? YES NO

Are your work activities affected as a result of this accident? YES NO

Since this injury, are your symptoms IMPROVING THE SAME GETTING WORSE

Have you received a previous aware for permanent damage in this claim? YES NO If so, what percent? _____%

_____ _____

Patient Signature Date