WORKER'S 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 determine what kind of care you will need. If we do not sincerely believe your condition will respond to chiropractic care, we will refer you for outside care accordingly. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you from Doctor and staff.

Date _____ Name _____

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

Address _____ City _____ State _____ Zip _____

Occupation _____ Who referred you to our office? _____

Social Sec. # _____-_____-_____ Bus. Phone (___)_____-_____ Company Name _____

Spouses Name _____ Spouse's SS # _____-_____-_____ Employer _____

E-mail address:_____ (to receive health information from our office)

Please explain in detail how your accident happened _____

_____

_____

_____

Did you report this injury in writing at your work? *Yes* *No*

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 _____ 20_____

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 the 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 _____

_____

Have you ever had a Workmen's Compensation claim before? *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?*

INJURIES INVOLVING LIFTING:

From what level were you lifting the object? _____

How many pounds was the object you were lifting? _____

What position were you in while you were lifting the object? _____

What type of pain did you feel immediately after the injury? _____

INJURIES INVOLVING FALLING:

Where at work did you fall? _____

What part of your body did you land on? _____

What other areas did you injure as a result of your fall? _____

OTHER TYPES OF ACCIDENTS:

_____

_____

JOB ANALYSIS:

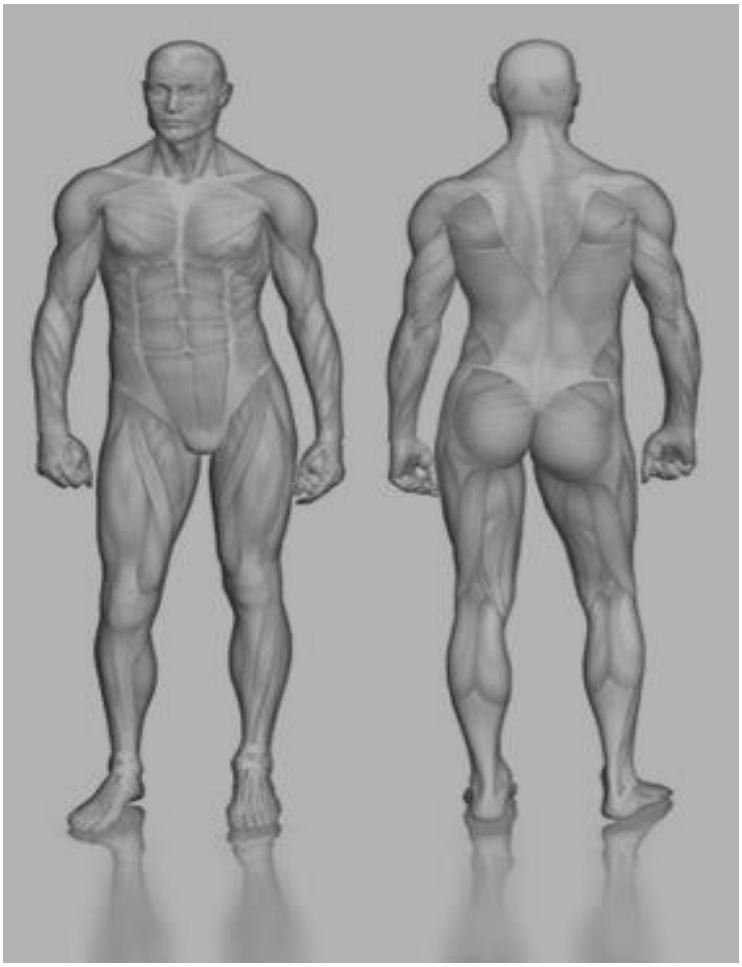
What regular activities do you perform at your job? (such as bending, squatting, lifting, etc.) _____

_____

How much do you regularly lift at your job? _____

Are you required to regularly bend while lifting at your job? _____

Please indicate the areas of pain with X's and areas of numbness or tingling with O's



HEALTH QUESTIONNAIRE:

Height: _____

Weight: _____

When was your blood pressure last taken?

_____

What was your blood pressure?

_____

Do you have a family history of High Blood Pressure? *YES NO*

Please indicate for 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 in breast

Are you pregnant?

____ Yes ____ No

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

____ Depression

CARDIO-VASCULAR-RESPIRATORY SYSTEM

____ Chest pain

____ Pain over heart

____ Difficulty breathing

____ Persistent cough

____ Coughing phlegm

____ Rapid heartbeat

____ Blood pressure problems

____ Heart problems

____ Lung problems

____ Varicose veins

EYE, EAR, NOSE, AND THROAT

____ Eye strain

____ Eye inflammation

____ Vision problems

____ Ear pain or noises

____ Hearing loss

____ Ear discharge

____ Nose pain

____ Nose bleeding

____ Difficult breathing thru nose

____ Dental problems

____ Popping noise in jaw

____ Sore mouth

____ Sore throat

____ Difficulty swallowing

____ Difficult speech

INSURANCE INFORMATION

Name of person responsible for this account? _____

Relationship to patient_____ Phone # _____

Address_____ City_____ State _____ Zip _____

Name of insured (employer or company name) _____

Address_____ City _____ State _____ Zip _____

Insurance Co._____ Phone # _____

Address_____ City _____ State _____ Zip _____

Date of Injury _____ Claim # _____

ADDITIONAL INSURANCE (Secondary Insurance)

YesNo If Yes Complete the following:

Name of insured (employer)_____ Relationship to Patient _____

Birth date_____ Insurance Co._____ Phone # _____

Group # _____ Employer #_____

Insurance Co. Address_____ City_____ State____ Zip _____

How much is your deductible?_____ How much have you used?_____ Max. annual benefit?_____