

WORKER'S COMPENSATION QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Date _____
Patient _____ No. _____
Sex: _____ Marital Status: _____ Date of Birth: _____ Home Phone: _____
Mobile: _____ Email: _____
Address: _____ City: _____ State: _____ Zip _____
Occupation _____
Type of work you do (labor) _____
Who referred 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 _____