Telm
CHIROPRACTIC CENTER, S.C.

WORKERS COMPENSATION QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Patient _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ S/S# _____

Name of Compensation Carrier: _____ Phone ( ) _____

Address of Carrier: _____ City _____ State _____ Zip _____

Employer's Name: _____ Phone ( ) _____

Employer's Address _____ City _____ State _____ Zip _____

1. Type of Business _____ Your Occupation _____

2. Date injured _____ Hour _____ AM / PM Last Date Worked _____ Are you off work? ( ) Yes ( ) No

3. Previous Worker's Compensation Injury? ( ) Yes ( ) No

4. Accident reported to employer? ( ) Yes ( ) No Name of person reported accident to _____

5. Injured at: _____ City _____ State _____ Zip _____

6. Length of time worked there prior to accident: _____

7. Type of work being done at time of injury: _____

_____

8. In your own words, please describe accident: _____

_____

_____

_____

9. Have you been treated by another doctor for this accident? ( ) Yes ( ) No
   if yes, please list doctor's name and address: _____

_____

   What type of treatment did you receive? _____

   How long were you treated by this doctor? _____

10. Are you: ( ) improved ( ) unchanged ( ) getting worse

11. What types of medicines are you taking? _____

_____

Do these medicines help? ( ) Yes ( ) No ( ) Don't know

12. Have you had physical therapy? ( ) Yes ( ) If yes, how often?
   ( ) Daily ( ) Every other day ( ) Several times a week ( ) Weekly ( ) Every other week

   ( ) Monthly ( ) Other _____

   Does the physical therapy help? ( ) Yes ( ) No ( ) Don't know

13. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?

( ) Yes ( ) No ( ) Don't know

If yes, describe: _____

Were these similar complaints the results of a previous accident(s)? ( ) Yes ( ) No

Please provide details of accident(s): _____

14. Have you had any other serious accidents which required medical care? ( ) Yes ( ) No

Describe: _____

15. Have you had any serious illnesses that required hospitalization? ( ) Yes ( ) No

Describe: _____

16. Have you had any surgeries? ( ) Yes ( ) No

If yes, list type of surgery and date: _____

17. Have you had any nervous or mental illnesses?

Have you had psychiatric care? ( ) Yes ( ) No

18. Have you received a medical discharge from the Armed Forces? ( ) Yes ( ) No

19. Have you returned to work since this accident? ( ) Yes ( ) No

CURRENT MEDICAL COMPLAINTS

BACK PAIN:

1. Currently, I have pain in my:	( ) low back	( ) mid back	( ) upper back
2. My pain began:	( ) gradually	( ) suddenly	
3. I have pain:	( ) sometimes	( ) all of the time	
4. My pain goes into my:	( ) right leg	( ) left leg	( ) both
5. I have tingling and/or numbness in my:	( ) right leg	( ) left leg	( ) both
6. My pain is worse when I:			
cough or sneeze	( ) Yes	( ) No	
sit	( ) Yes	( ) No	
bend	( ) Yes	( ) No	
walk	( ) Yes	( ) No	
lift	( ) Yes	( ) No	
push	( ) Yes	( ) No	
pull	( ) Yes	( ) No	
7. My back is worse with sexual activity	( ) Yes	( ) No	
8. My pain wakes me up during the night	( ) Yes	( ) No	
9. Changes in the weather affect my pain	( ) Yes	( ) No	

NECK PAIN:

1. I have pain in my:	( ) neck	( ) head	
2. I have pain	( ) sometimes	( ) all of the time	
3. My pain goes into my:	( ) right arm	( ) left arm	( ) both
4. I have tingling and/or numbness	( ) right arm	( ) left arm	( ) both
5. My pain is worse when I:			
cough or sneeze	( ) Yes	( ) No	
bend forward	( ) Yes	( ) No	
lift	( ) Yes	( ) No	
push	( ) Yes	( ) No	
pull	( ) Yes	( ) No	
turn my head	( ) Yes	( ) No	
6. My pain wakes me up during the night	( ) Yes	( ) No	
7. Changes in the weather affect my pain	( ) Yes	( ) No	
8. I have neck stiffness	( ) Yes	( ) No	
9. I have headaches	( ) Yes	( ) No	
10. If I do get headaches, they occur:	( ) sometimes	( ) all the time	

Signature _____ Date _____