



WORKER'S COMPENSATION QUESTIONNAIRE

Please answer all questions completely

Dear Patient: This information is considered confidential. 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 _____ Home Phone _____ SS# _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Date Of Birth _____ Male Female

Single Widowed Divorced Married – if yes, does spouse work? Yes No

Occupation when injured _____ Date of Injury _____ Time of injury _____ a.m./p.m.

Employer's Name _____ Employers Phone Number _____

Employer's Address _____ City _____ State _____ Zip _____

Employers Insurance Company _____ Policy No. _____

Mailing Address _____ City _____ State _____ Zip _____

Please explain in detail how your accident happened _____

Did you report the injury to your foreman or employer? Yes No Did they recommend care at our clinic? Yes No

List the extent of your injuries as you know them. _____

Did you continue to work after the accident? Yes No

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

Have you lost any days of work? _____ Dates: _____

Since this injury, are your symptoms Improving? Getting worse? Same? Did you consult any other doctor? Yes No

If so, give doctor's name _____

Doctor's diagnosis _____

What treatments did you receive? _____

How often did you see the doctor? _____

Have you been using any home remedies? _____ If so, what, and were they effective? _____

Have you ever been injured in 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. _____

Have you ever been involved in any other type of accident, fall, or had a broken bone, etc.? Please give brief description. _____

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 _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? Yes No

Name of Insurance Adjuster _____

Have you retained an attorney? Yes No Litigation? Yes No Maybe

If so, Name and Address: _____