

WORKERS COMPENSATION QUESTIONNAIRE

Today's Date: _____

Please fill out the answers to the following questions to the best of your ability. If you have any difficulty with any questions or are unsure of how best to answer, please discuss those questions with the doctor before answering. Thank you! Chiropractic Professional Center.

Last Name: _____ First Name: _____

Age: _____ Weight: _____ Height: _____

Are you: () Married () Single () Divorced () Separated () Widowed () Living with a significant other

Are you a parent? NO Yes, with 1 2 3 4 5 6 Children

Occupation: _____ For how long: _____ years, _____ months

Make and model of the vehicle you were in _____ Year _____

Date of Accident (___/___/___) Which state did the accident take place in? _____

Please answer the following questions.

Where and how did the accident happen? _____

Did you report the injury? () NO or () YES

Have you had any other accidents or injuries since this accident? **NO or YES, if yes please explain.**

Please complete one or more of the following statements.

Since the accident, my injury **prevents** me from _____

Example: Since the accident, my injury prevents me from playing basketball, helping around the house and running. I did these things before the injury.

Since the accident, I have been **unable** to _____

Example: Since the accident, I have been unable to go to school, make the beds, clean the house, drive the car or put on my own shoes.

Since the accident, I have had **difficulty** _____

Example: Since the accident, I have had difficulty standing, sitting, working, sleeping, bending and lifting my child.

I have not been able to work () since the accident, or () since (___/___/___)

() I have not seen a doctor for this injury until now. This appointment is my first since the accident.

() I have seen a doctor _____ Date: _____

Address _____

Phone #: () _____ - _____