WORKERS' COMPENSATION QUESTIONNAIRE

Dear Patient: Date_____

We need this confidential information answered completely to help us assess your need for care. If we do not sincerely believe your condition will respond to chiropractic care, we will not accept you as a patient. Thank You.

General Information:

Name_____ Sex ___ Marital Status _____ Date of Birth_____ Home Phone ( )_____

Address _____ City_____ State_____ Zip_____

Occupation _____ Work Phone ( ) _____ OK to call there? _____

Nature of Accident:

1. What was the time and date of this present injury? _____ AM _____ PM _____ 20_____

2. Please explain in detail how your accident happened. (Please include location, condition of area and equipment involved.) _____

_____

_____

_____

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING IMMEDIATELY AFTER ACCIDENT.

Mark the areas on this body where you felt the described sensations. Use the appropriate symbols in all affected areas.

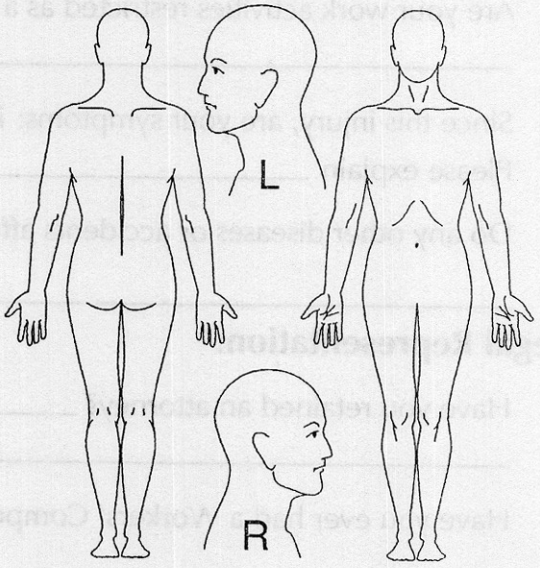
Numbness	Pins & Needles	Burning	Aching	Stabbing
xxxxxxxxxx	.....	oooooo	vvvvvvv	IIIIIIIIIIIIIII
xxxxxxxxxx	.....	oooooo	vvvvvvv	IIIIIIIIIIIIIII
xxxxxxxxxx	.....	oooooo	vvvvvvv	IIIIIIIIIIIIIII

3. Where did you feel pain or unusual feeling immediately after the accident? (Please show the areas on the diagram also.) _____

_____

_____

_____



4. Were you unconscious as a result of the injury? _____
   If yes, how long?_____
5. Were you bleeding as a result of the injury? _____
6. Did you leave the work area after the accident to seek medical attention? _____ Please explain _____

_____

7. Did you consult any other doctor? _____
   Doctor's name? _____ ____ DC ____ MD____ DO ____ DDS

8. Describe the doctor's diagnosis_____

9. What treatment did you receive? _____

10. Are you still under a doctor's care?_____ If yes, please explain _____

Past History:

1. Have you ever injured this area before? _____ If yes, when? _____
2. If injured before, did you lose time from work? _____
3. If you lost time from work with injuries prior to this injury, give name of doctor or doctors consulted.

   _____
4. Have you been involved in any previous accidents of any kind (personal injury, automobile accident or workers' compensation)? _____ If yes, please explain dates and details _____

   _____

   _____
5. Have you been treated previously by a chiropractor? _____ If yes, please explain _____

   _____

Present Information/Disability:

1. Have you returned to work? _____ If yes, date returned to work _____
2. Job description _____
3. Do you have to favor any part of your body in your work? _____ If yes, please explain _____

   _____
4. Are your work activities restricted as a result of this accident? _____ If yes, please explain _____

   _____
5. Since this injury, are your symptoms: improving _____, getting worse _____ or the same _____ ?
   Please explain _____
6. Do any other diseases or accidents affect your employment? _____ If yes, please explain _____

   _____

Legal Representation:

1. Have you retained an attorney? _____ If yes, name and address _____

   _____
2. Have you ever had a Workers' Compensation claim before? _____

I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____ _____

Patient's Signature Date

_____ _____

Doctor's Signature (upon review) Date

WORKER'S COMPENSATION AUTHORIZATION

DATE: _____

EMPLOYER: _____

ADDRESS: _____

_____

EMPLOYEE: _____

ADDRESS: _____

_____

DATE OF ACCIDENT: _____

INSURANCE CARRIER: _____

ADDRESS: _____

_____

BY PHONE _____ TALKED WITH _____

(date) (name)

_____ HAS CONSULTED THE _____ CLINIC FOR EXAMINATION AND TREATMENT. PLEASE SIGN AND RETURN TO THE _____ CLINIC THIS WRITTEN AUTHORIZATION FOR TREATMENT.

_____

Signature, Title

_____

Date

