

Worker's Compensation Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. 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 _____ Sex _____ Marital Status _____ Date of Birth _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Occupation _____ who referred you to our office? _____

Please explain in detail how your accident happened? _____

Give the time and date present injury occurred AM PM 20 _____

Where did you feel pain immediately after the accident? _____

Rate your pain on a scale of 1-5 slight 1 2 3 4 5 severe

Did you return to work? Yes No _____ Supervisor's Name _____

Did you consult any other doctor? Yes No _____ If yes, date _____

If so, give doctor's name _____ D.C. M.D. D.O. D.D.S.

Did you file a report? Yes No _____ Supervisor's Name _____

Has this injury happened before? Yes No

If you answered yes to the above question, did you claim that injury on workers' compensation? Yes No

If you answered yes to the above question, did you receive a full medical release to go back to work? 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

Do any other diseases or accidents affect your employment? Yes No If so, explain _____

Insurance Company Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Claim number to be used for billing _____

Coverage: According to Michigan Workers' Compensation Law, an injured employee has "freedom of choice" in regard to health care. Specifically, the employer can determine the health care for the first ten days following first medical care for the injury. After ten days have elapsed, the employee may choose any doctor and receive health care under workers' compensation.

Patient's Signature _____

Health Questionnaire

Please indicate for each of the questions below your experience by use of the following codes: 1-Never Had; 2-Previously Had; 3-Presently Have

Musculo-Skeletal System

- Low back problems
- Pain between shoulders
- Neck problems
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Ruptures
- Broken bones

Genito-Urinary System

- Bladder Trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

Female

- Vaginal discharge
- Vaginal bleeding
- Breast pain
- Lumps on breast
- Are you pregnant?
- Yes No

Gastro-Intestinal System

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive Thirst
- Nausea
- Vomiting food
- Vomiting blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

Cardio-Vascular Respiratory System

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

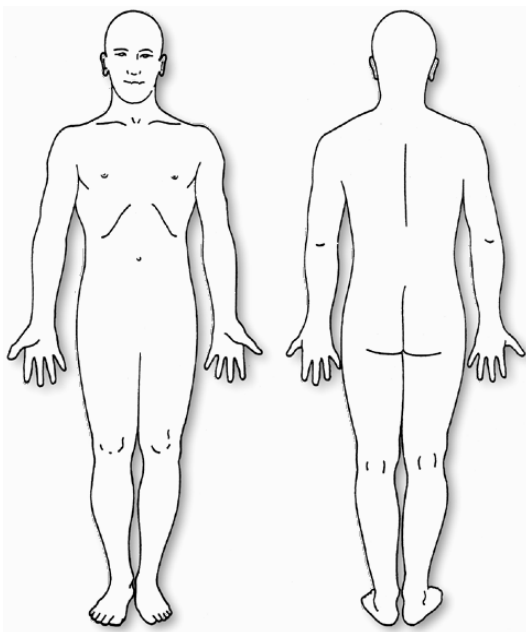
Eye, Ear, Nose, and Throat

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Nose pain
- Nose discharge
- Difficult breathing thru nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech

Nervous System

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression

Please mark your areas of pain on the figures below:



Patient's Signature _____

Do Not Write Below This Line

Patient Accepted? Yes No Doctor's Signature _____