

KHALSA CHIROPRACTIC
WORKMEN'S COMPENSATION QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Name _____ Date of Birth _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Employer's Name _____

Employer's Address _____ Phone _____

Nature of Business (e.g. food manufacturer, building construction, etc.) _____

Patient's Occupation (specific job title) _____

Please explain in detail how your accident happened _____

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

If so, name and address _____

Give time and date present injury occurred _____ () AM () PM _____ 20 _____

Where did you feel pain immediately after the accident? _____

Did you return to work? () Yes () No If so, date returned to work _____

Did you consult any other doctor? () Yes () No

If so, give Doctor's name _____ () DC () MD () DO () DDS

Doctor's diagnosis _____

What treatments did you receive? _____

Have you ever injured 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 _____

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 _____

Do you have a history of absenteeism caused from accidents on the job? () Yes () No

Have you ever had a Workman's Compensation claim before? () 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

Since this injury are your symptoms () Improving? () Getting worse? () The same?