Workmen'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.

Date of Accident: ______________ Hour ________ AM ___ PM Location ______________________________

Did you report the injury to your foreman or employer? ☐ YES ☐ NO

Did he (they) recommend care at our clinic? ☐ YES ☐ NO

List the extent of the injuries as you know them ______________________________

____

____

Please explain in detail how your accident happened ______________________________

____

____

____

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______________________________ ☐ D.C., ☐ M.D., ☐ D.O., ☐ D.D.S.

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 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 ______________________________

____

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 Workmen's Compensation claim before? ☐ YES ☐ NO

Have you been contacted by an insurance adjuster or company representative regarding this claim ☐ YES ☐ NO

Name of your insurance adjustor______________________________

Have you retained an attorney? ☐ YES ☐ NO Litigation? ☐ YES ☐ NO ☐ Maybe

If so, name and address ______________________________

HEALTH QUESTIONNAIRE:

Please indicate for each of the questions below your experience by use of the following codes: C-Current; P-Past

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
_______ Arthritis

GENITO-URINARY SYSTEM

_______ Bladder trouble
_______ Excessive urination
_______ Scanty urination
_______ Painful urination
_______ Discolored urine

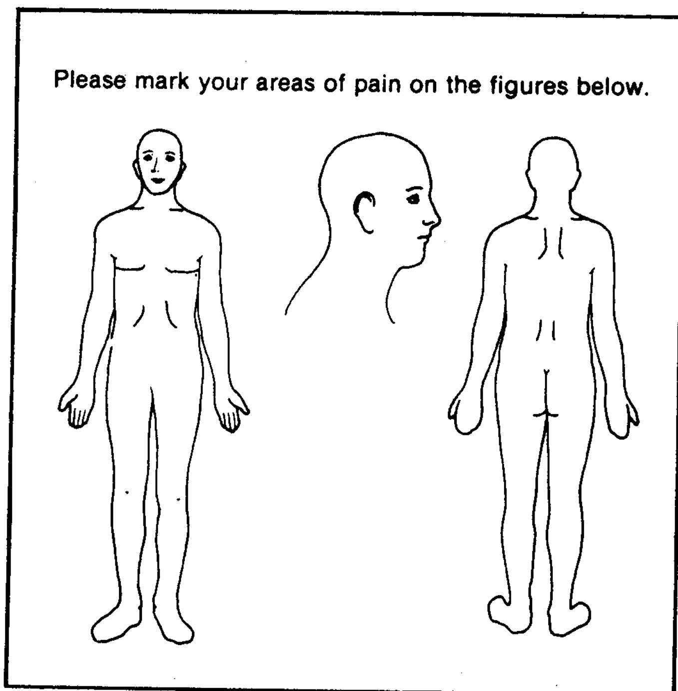
FEMALE

_______ Vaginal discharge
_______ Vaginal bleeding
_______ Vaginal pain
_______ Breast pain
_______ Lumps on breast

Are you pregnant?

_______ Yes _______ No

Please mark your areas of pain on the figures below.



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

NERVOUS SYSTEM

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

OTHER

_______ Diabetes
_______ Anemia
_______ Rheumatic Fever
_______ Cancer
____

CARDIO-VASCULAR-RESPIRATORY

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

EYE, EAR, NOSE, AND THROAT

_______ Eye strain
_______ Eye inflammation
_______ Vision problems
_______ Ear pain
_______ Ear noises
_______ Hearing loss
_______ Ear discharge
_______ Nose pain
_______ Nose bleeding
_______ Nose discharge
_______ Difficult breathing thru nose
_______ Sore gums
_______ Dental problems
_______ Sore mouth
_______ Sore throat
_______ Hoarseness
_______ Difficult speech
_______ Sinus Trouble

____
____
____

---------- **DO NOT WRITE BELOW THIS LINE** ----------

____
____
____

Patient accepted? Yes _______ No _______ Doctor's signature _______________