WORKER'S COMPENSATION QUESTIONNAIRE

Please answer all questions completed and return to office.

Employee's name & address: _____

_____

_____

Phone number: _____

Occupation: _____

Age: _____ Sex: ☐ M ☐ F

Employer's name & address: _____

_____

_____

Phone number: _____

Type of business (retail, manufacturing, construction, etc.) _____

_____

Workers Compensation Insurance Carrier: _____

On what date did your injury occur? _____ What time? _____ AM PM

What address were you at when you were injured? _____

_____

Did you notify your employer of this injury? ☐ Yes ☐ No

Have you retained an attorney? ☐ Yes ☐ No

If Yes, please give name & address: _____

_____

_____

Are you currently in litigation for this injury? ☐ Yes ☐ No ☐ Maybe

Please explain how the injury or illness occurred: _____

_____

_____

What injuries did you suffer? _____

_____

_____

When was the last day you worked? _____

When did you return to work? _____

When was your first examination? _____

Who examined you? _____

_____

_____

Check one, if known: ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S.

What was doctor's diagnosis? _____

(Please complete opposite side.)

Have you received any treatments prior to visiting this office? ☐ Yes ☐ No

What treatments did you receive? _____

_____

Have you ever injured this area before? ☐ Yes ☐ No

If Yes, when did the injury occur? _____

Did you lose time from work? ☐ Yes ☐ No

If you lost time from work with injuries prior to this injury, please list doctor or doctors consulted: _____

_____

_____

Do you have other injuries or illnesses that affect your employment? ☐ Yes ☐ No

If Yes. please explain: _____

_____

In your work, do you favor one part of your body more than others? ☐ Yes ☐ No

If Yes. please explain: _____

_____

Do you hive a history of absenteeism caused from accidents on the job? ☐ Yes ☐ No

Have you ever had a Worker'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?

WORKER'S COMPENSATION AUTHORIZATION

Patient Name _____

Date of Accident _____

Disability: Date Last Worked _____ Date Returned to Work _____

Employer Name _____

Address _____

_____

Phone _____

Person to Contact _____

Worker's Compensation Carrier

Name _____

Address _____

_____

Phone _____

Person to Contact _____

Do you wish billing to be forwarded to employer or insurance carrier?

☐ Employer

☐ Insurance Carrier

The above patient has advised me of his work-related injury and that he/she is being treated by:

Provider Name _____

Address _____

_____

Phone _____

Person to Contact _____

_____ _____

Signature Authorized Representative Date

_____

Please Print Name