CHIROPRACTIC SPORTS & WELLNESS PC WORKER'S COMPENSATION IJURY QUESTIONAIRE

Please Print

Name:____ Today's Date:___________________________

Employer's Business Name at time of Accident:____

Employer's Phone:_______________________ Employer's Address:___________________________________

Occupation:____ Impairment Rating: (if known)_________________

Length of time at this job prior to injury: ____

Date of Injury: _________________ Time of Injury: _________________ Last Date Worked: ____________________

Please explain what you were doing at the time you were injured and how the accident happened (lifting, walking, carrying standing, etc) ____

____

When did the pain begin? (Please be specific) ____

When did you first feel it? (Please be specific) ____

Was the pain intense at first or did it gradually worsen? ___________________________________

Previous Worker's Compensation Injury? ☐Yes ☐ No Date of previous injury(s):______________________

If yes, please describe the injury:____

REPORT ACCIDENT/ACCIDENT OBSERVER

What date did you report this injury on? ____

Who did you report this injury to? ___________________________________ Position? _________________________

Did anyone else observe accident/injury? ☐Yes ☐No If yes, Name:___________________________________

Position: _______________________________

SYMPTOMS FROM ACCIDENT

Did you experience bleeding, cuts or bruises? ☐Yes ☐No

If bleeding or cuts, where? ______________________________ If bruises, where? ______________________________

Please describe how you felt: PLEASE BE SPECIFIC

Immediately after the accident: ____

Later that Day Night: ____

The next day(s): ____

____

Check symptoms that have been apparent since, or have worsened since the accident/injury

☐Nervousness	☐Loss of balance	☐Sleeping Trouble	☐Headache	☐Fainting
☐Neck Pain/Stiffness	☐Loss of smell	☐Toe Numbness	☐Anxiety	☐ Seizures
☐Ringing/buzzing ears	☐Loss of taste	☐Finger Numbness	☐Cold Hands	☐ Cold Feet
☐Low Back Pain	☐Loss of memory	☐Blurred Vision	☐Chest Pain	☐Constipation
☐Eyes- light sensitive	☐Pins/Needles –Arms	☐Diarrhea	☐Fatigue	☐Depression
☐Pain behind eyes	☐Pins/Needles – Legs	☐Dizziness	☐Confused	☐Disoriented
☐Shortness of breath	☐Double Vision	☐Forgetfulness	☐Tension	☐Cold Sweats
☐Heads seems heavy	☐Mid back Pain	☐Face Flushed	☐Irritability	☐Fever
☐Visual Disturbance	☐Other: __________________________			

MECHANISM OF INJURY:

Pleases explain the mechanism of the injury (only fill in the sections that apply to you)

FALL

☐Yes ☐No Did you hit anything when you fell? If yes, what? ____

☐Yes ☐No Were you carrying anything when you fell? If yes, what? __________________________________

How much did it weigh? _______________ lbs

☐Yes ☐No Did you twist when you fell? If so, to which side? ☐Left ☐Right

☐Yes ☐No Was the area lighted?

Describe the condition of the area (slippery, graveled, etc) ____

What part of the body did you fall on? ____

How far did you fall? (In feet) ____

What did you land on? ____

LIFT/PULL

How much did the object weigh? ____________________________ lbs

☐Yes ☐ No Did you fall after the injury? If yes, how far? ____

☐Yes ☐No Did you hit anything when you fell? If yes, what? ____

☐Yes ☐No Were you twisting when you were lifting/pulling? If yes, to which side? ☐ Left ☐Right

How far off the ground did you have the object before the pain started? _____________________________________

☐Yes ☐ No Did you drop the object when the pain started?

☐Yes ☐ No Did it land on you? Where? ____

Did you lift your: ☐Legs ☐Back ☐Other ____

BEND:

☐Yes ☐ No Were you lifting when you bent over? If yes, how much did the object weigh? _____________ lbs

How far did you bend over? ____

☐Yes ☐No Did you fall when the pain started? How far? ____

☐Yes ☐ No Were you twisting when you bent forward? Toward which side? ☐Left ☐Right

☐Yes ☐ No Did you land on anything? If so, what? ____

WORK STATUS HISTORY:

☐Yes ☐ No Have you lost time from work as a result of this new injury? If yes, give dates: _______________

____

☐Yes ☐No Have you gone back to work? When? ____

If yes, status of work: ☐Modified ☐Regular

List restrictions that you have been placed on: ____

If you have gone back to work, list the activities that are:

PAINFUL ____

DIFFICULT ____

☐Yes ☐ No If you are currently on disability (time loss), do you want to go back to work doing your regular job? If no, why not? ____

☐Yes ☐No Are there any problems you have with a fellow employee, supervisor, or manager that needs to be discussed? If yes, please explain: ____

____

PATIENT WORKER'S COMPENSATION INFORMATION SHEET

INSTRUCTIONS: The following information is needed upon your arrival here at CHIROPRACTIC SPORTS & WELLNESS PC. Please take this time to complete the appropriate information below as it relates to your injury. This information is used for billing purposes only. If you do not have this information available at this time, please let a staff member know. You will be required to have the information completed and returned upon you next visit.

Patient Name: ____

Date of Accident/Injury/Loss: ____

WORKER'S COMPENSATION INFORMATION

An accident report must have been filed with your employer for charges to be covered and a workers compensation form must also be completed. If our clinic is not part of your employer's worker's compensation panel, you may be required to go to a panel provider for and initial visit before requesting transfer of your case to this office. If you are unsure if we are part of your employer's panel, please ask a member of our staff for assistance.

Employer: ____

Employer's Phone #: ______________________________________ Ext. ______________

Employer's Address: ____

____

Human Resource Manager's Name: ____

Claim Number: ____