East Colonial Chiropractic
WORKERS COMP QUESTIONNAIRE

Dear Patient:

Please complete this questionnaire. 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. THANK YOU.

Date of Accident _____

Name _____ Social Security # _____

Address _____ City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____ Cell Phone _____

Age _____ Birthdate _____ # Children _____ Marital Status M S W D

Employer _____ Occupation _____

Spouses's Name & Phone# _____ Email: _____

Referred by _____ Nearest Relative & Phone _____

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1. Name of employer at time of accident: _____
2. Length of time worked there prior to accident: _____
3. Type of work being done at time of injury: _____

   _____
4. In your own words, please describe accident: _____

   _____

   _____

   _____
5. Have you been treated by another doctor for this accident? ☐ Yes ☐ No

   If yes, please list doctor's name and address: _____

   _____

   What type of treatment did you receive? _____

   How long were you treated by this doctor? _____
6. Are you: ☐ Improved ☐ Unchanged ☐ Getting worse
7. Have you had physical therapy? ☐ Yes ☐ No

   If yes, how often? ☐ Daily ☐ Every other day ☐ Several times a week ☐ Weekly ☐ Every other week

   ☐ Monthly ☐ Other _____
8. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?

   ☐ Yes ☐ No ☐ Don't know

   If yes, describe: _____

   _____

   _____

   Were these similar complaints the result of a previous accident(s)? ☐ Yes ☐ No

   Please provide details of accident(s): _____

   _____

   _____

9. Have you had any other serious accident which required medical care? ☐ Yes ☐ No

   Describe: _____

10. Have you had any serious illness that required hospitalization? ☐ Yes ☐ No

    Describe: _____

    _____

    _____

11. Have you had any surgeries? ☐ Yes ☐ No

    If yes, list type of surgery and date: _____

    _____

    _____

12. Have you returned to work since this accident? ☐ Yes ☐ No

    If you have returned to work since your accident, please fill out the information below:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY REG. DUTY	FULL-TIME PART-TIME

Please describe your present complaints and symptoms:

_____

_____

_____

_____

_____

_____

OTHER PAIN:

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition:

_____

_____

_____

_____

_____

I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo treatment and I hereby give my consent for treatment.

Signature _____ Date _____