

WORKERS' COMPENSATION QUESTIONNAIRE
ROOTS WELLCARE, PA

Name _____ Date _____

Nature of Accident

What was the date and time of this present injury? _____ AM _____ PM _____, 20 _____

Please explain in detail how your accident happened. Please include location, condition of area and equipment involved. _____

Where did you feel pain or unusual feeling immediately after the accident? _____

Were you unconscious as a result of this injury? (circle one): Yes No - If Yes, for how long?

Were you bleeding as a result of the injury? (circle one): Yes No

Did you leave the work area after the accident to seek medical attention? (circle one) Yes No

Please explain: _____

Have you consulted any other doctor? _____ Name _____

If yes, what was his/her diagnosis? _____

Please describe type of treatment received _____

Are you still under a doctor's care? _____ If yes, please explain _____

Past History

Have you ever injured this area before? _____ If yes, when? _____

If injured, did you lose time from work? _____

If you lost time from work with injuries prior to this injury, give name of doctor (s) consulted.

Have you been involved in any previous accidents of any kind (personal injury, motor vehicle accident or workers' compensation)? (circle one): Yes No – If yes, please explain dates and details _____

Previous chiropractic treatment (Dr name, nature of problem) _____

Present Injury and Disability

Have you returned to work? _____ If yes, date returned to work _____

Job description _____

Do you have to favor any part of your body in your work? _____ If yes, please explain _____

Are your work activities restricted as a result of this accident? _____ If yes, please explain _____

Since this injury, are your symptoms: improving _____, getting worse _____, or the same _____?

Legal Representation

Have you retained an attorney? _____ Name, address _____

Have you ever had a Workers' Compensation claim before? _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered.

Patient Signature

Date