

**WORKERS' COMPENSATION QUESTIONNAIRE
ROOTS WELLCARE, P.A.**

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? Yes _____ No _____ ; if yes, for how long? _____

Were you bleeding as a result of this injury? Yes _____ No _____

Did you leave the work area after the accident to seek medical attention? Yes _____ No _____

Please explain: _____

Have you consulted any other doctor? Yes _____ No _____ Name _____

If yes, what was his/her diagnosis? _____

Please describe type of assessment and treatment received: _____

Are you still under a doctor's care for this injury? Yes _____ No _____ If yes, please explain: _____

Past History

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

If injured, have you lost time from work? Yes _____ No _____ If yes, how many days? _____

If you lost time from work with injuries PRIOR to this injury, please give name of doctor(s) consulted: _____

Have you been involved in any previous accidents of any kind? If yes, please describe below.

Personal injury _____

Motor vehicle accidents _____

Work-related injuries _____

Previous chiropractic treatment? Please give doctor name, and nature of problem: _____

Present Injury and Disability

Have you returned to work? Yes ___ No ___ If yes, date returned to work: _____

Please describe your job duties: _____

Do you have to favor any part of your body in your work? Yes ___ No ___ If yes, explain: _____

Are your work activities restricted as a result of this accident? Yes ___ No ___ If yes, explain: _____

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

Legal Representation

Have you retained an attorney? Yes ___ No ___ 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