performancehealth
SPINE & SPORT THERAPY

WORKER'S COMPENSATION QUESTIONNAIRE

Patient Name: _____ Sex: _____ Age: _____ DOB: _____

Patient Address: _____

Employer: _____ Contact: _____

Employer's Address: _____ Phone: _____

WC Carrier: _____ WC Claim #: _____

Date and Time of Accident: _____ Location: _____

Where were you taken after the accident? _____

Where did you feel pain? _____

What are your symptoms? _____

Name(s) of other doctor(s) consulted for this accident: _____

Other treatment received: _____

Did you miss any work? _____ If so, date returned to work: _____

Briefly explain how the accident occurred: _____

Are your work activities restricted as a result of your accident? _____

Have you previously been injured in a similar manner? _____

Do you have or have you had any other diseases/conditions that affect your employment? _____

Do you have to favor any part of your body during the course of your employment? _____

Were you capable of working on an equal basis with others your age before your injury? _____

What is your present occupation? _____

Since the injury, is your condition: Same _____ Worse _____ Improving _____

Have you retained an attorney? _____

If so, list name, phone & address of attorney: _____

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