

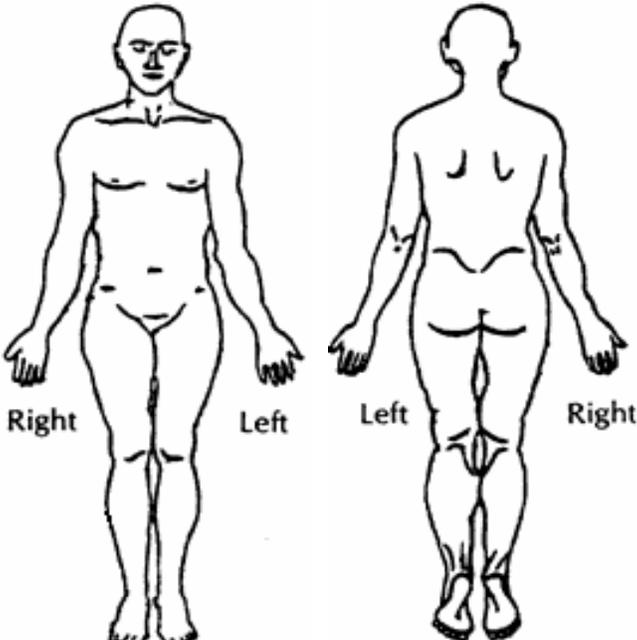
WORKER'S COMPENSATION QUESTIONNAIRE

This information will be strictly confidential. Your answers will help us determine if chiropractic care will benefit you. Please print and be as accurate and complete as possible. Thank you.

PATIENT INFORMATION

NAME Last		First	Middle	DATE
ADDRESS		CITY	STATE	ZIP
HOME PHONE	CELL PHONE		BUSINESS PHONE	
SOCIAL SECURITY #	BIRTH DATE	HEIGHT	WEIGHT	SEX
MARITAL STATUS	NO. OF CHILDREN	HOW WERE YOU REFERRED TO OUR OFFICE?		
EMPLOYER		OCCUPATION		
BUSINESS ADDRESS			E-MAIL ADDRESS	

ACCIDENT INFORMATION

GIVE DETAILS OF HOW ACCIDENT OCCURRED:																													
DATE AND TIME OF ACCIDENT: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	WAS YOUR EMPLOYER NOTIFIED? <input type="checkbox"/> No <input type="checkbox"/> Yes Name of person notified:	HAS YOUR EMPLOYER AUTHORIZED TREATMENT? NAME OF PERSON AUTHORIZING:																											
PLEASE DESCRIBE YOUR INJURIES AND SYMPTOMS RESULTING FROM THIS ACCIDENT:																													
DID YOU CONSULT ANOTHER DOCTOR? <input type="checkbox"/> No <input type="checkbox"/> Yes	DOCTOR'S NAME:	HOW OFTEN DID YOU SEE THIS DOCTOR?																											
WHAT TREATMENT AND DIAGNOSIS WAS GIVEN?																													
ANY PRIOR INJURIES OR SYMPTOMS TO THE SAME AREA(S)? IF YES, PLEASE DESCRIBE <input type="checkbox"/> No <input type="checkbox"/> Yes																													
SINCE THIS INJURY, ARE YOUR SYMPTOMS: <input type="checkbox"/> Improving <input type="checkbox"/> The Same <input type="checkbox"/> Getting Worse		DID YOU OR ARE YOU STILL TAKING ANY MEDICATIONS FOR THIS INJURY? <input type="checkbox"/> No <input type="checkbox"/> Yes																											
LIST TWO MAJOR COMPLAINTS, AND CIRCLE THE INTENSITY OF PAIN. <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;"></th> <th style="width: 5%;">LOW</th> <th style="width: 5%;">MODERATE</th> <th style="width: 5%;">INTENSE</th> <th style="width: 5%;">EMERGENCY</th> </tr> </thead> <tbody> <tr> <td>COMPLAINT # 1: _____</td> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td> </tr> <tr> <td>COMPLAINT # 2: _____</td> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td> </tr> </tbody> </table>			LOW	MODERATE	INTENSE	EMERGENCY	COMPLAINT # 1: _____	1	2	3	4	5	6	7	8	9	10	COMPLAINT # 2: _____	1	2	3	4	5	6	7	8	9	10	Mark areas of pain resulting from this accident on figures below: 
	LOW	MODERATE	INTENSE	EMERGENCY																									
COMPLAINT # 1: _____	1	2	3	4	5	6	7	8	9	10																			
COMPLAINT # 2: _____	1	2	3	4	5	6	7	8	9	10																			
AFTER THE ACCIDENT, DID YOU RETURN TO WORK? <input type="checkbox"/> No <input type="checkbox"/> Yes DATE:																													
HAS THIS INJURY RESTRICTED YOUR WORK? <input type="checkbox"/> No <input type="checkbox"/> Yes HOW?																													
HAVE YOU LOST WORK TIME DUE TO ANY PRIOR INJURIES? <input type="checkbox"/> No <input type="checkbox"/> Yes EXPLAIN:																													
HAVE YOU EVER HAD A WORKER'S COMPENSATION CLAIM BEFORE? <input type="checkbox"/> No <input type="checkbox"/> Yes EXPLAIN:																													
BEFORE THIS INJURY, WERE YOU ABLE TO WORK ON AN EQUAL BASIS WITH OTHERS YOUR AGE? <input type="checkbox"/> No <input type="checkbox"/> Yes EXPLAIN:																													
DO YOU HAVE ANY OTHER CONDITIONS THAT AFFECT YOUR WORK? <input type="checkbox"/> No <input type="checkbox"/> Yes EXPLAIN:																													
DO YOU FAVOR ANY BODY PART WHILE WORKING? <input type="checkbox"/> No <input type="checkbox"/> Yes Which one?																													
HAVE YOU RETAINED AN ATTORNEY? <input type="checkbox"/> No <input type="checkbox"/> Yes Attorney's Name:																													
Attorney's Address & Phone																													
IS THERE LITIGATION? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe																													

General Information

Employee: _____ Date: _____
Social Security #: _____ Accident Date: _____
Job Description: _____
Employer Name: _____
Contact Person: _____ Employer Phone: _____
Employer Address: _____
Street Address City State Zip

Assignment and Release

The state compensation fund provides for payment of medical services of accidental injuries which occur during the course of employment. Verification of a claim with your employer is mandatory to consider your case a Worker's Compensation claim. If we are unable to verify this with your employer or if your claim is denied, YOU will be expected to make other financial arrangements for the treatment received here.

Claimant Signature: _____ Date: _____

I hereby authorize and direct Acton Chiropractic & Rehabilitation, Inc to release all medical information necessary to process my claims.

Claimant Signature: _____ Date: _____

******FOR OFFICE USE ONLY******

W/C Carrier (Name and Address)	Utilization Review Agent
_____	_____
_____	_____
_____	_____
Phone#: _____	Phone#: _____
Claim #: _____	Fax #: _____
Adjuster: _____	Nurse: _____
Date verified: _____	Spoke With: _____
Staff Member: _____	