BROOKFIELD CHIROPRACTIC

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CHRISTIANSEN CHIROPRACTIC, S.C.
Dr. Matt Christiansen

HERRLE CHIROPRACTIC SERVICES, S.C.
Dr. Kevin Herrle

WORKERS' COMPENSATION QUESTIONAIRE

Patient Name:_____ Date: _____

INSURANCE INFORMATION

Your employer's name:_____ Phone #:_____

Your employer's workers' comp. insurance co.: _____ Phone #:_____

Address: _____

Claim#:_____ Service Representative:_____

Your health insurance co. _____ Phone #:_____

Address: _____

ID#:_____ Group #:_____

If you have retained an attorney: Name:_____ Phone#:_____

Address: _____

ACCIDENT INFORMATION

Please explain in detail how your accident happened:_____

_____

_____

_____

Give time and date present injury occurred: _____am/pm _____/_____/_____

Where did you feel immediate pain after the accident:_____

Did you report the accident to your supervisor? Yes No When? _____ Name:_____

Has your employer acknowledged your accident? Yes No

Have you missed any work? Yes No When?_____

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

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

Before this injury, were you capable of working on an equal basis with others your age? Yes No

List any other comments relative to this accident:_____

_____

List any other complaints/health concerns not directly related to this accident:_____

_____

INFORMATION REGARDING YOUR INJURY

Have you tried any home remedies for your injury (aspirin, heating pad, ice pack, etc)?_____

What aggravates your injury (i.e.; sitting, walking, bending, etc.)? _____

What makes your injury better? _____

Since the injury, are your symptoms: Getting better Worse About the same

Have you seen any other health care providers for this injury? Yes No (If yes, complete this section)

Doctor's names and addresses: _____

_____

What examinations/treatments did your receive? _____

_____

Doctor's diagnosis (if known): _____

Doctor's recommendations: _____

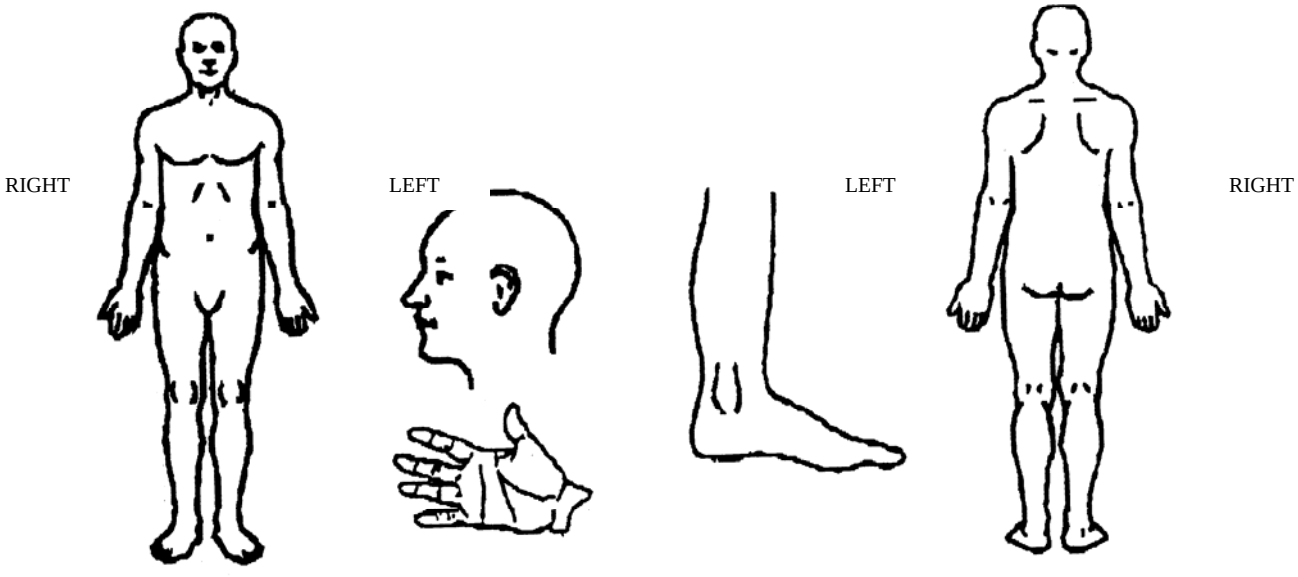
List any other comments relative to this injury: _____

_____

INJURY DETAIL

Please circle area(s) of injury and describe your symptoms using the codes listed below.

N - Numbness P - Pain T – Tingling A – Ache S – Soreness ST – Stiffness MSP – Muscle Spasm



I attest that the above given information is complete and accurate to the best of my knowledge.

Signature:_____ Date:_____