



Worker's Compensation Questionnaire

Employee's Name: _____ Date: _____

Occupation: _____

Employer's Name: _____

Employer's Address: _____

Type of Business: _____

When did the injury occur? Date: _____ Time: _____ AM / PM

What address were you at when you were injured?: _____

Did you receive authorization from your workplace to have treatment in this facility? Yes No

Have you retained an attorney? Yes No

If yes, attorney name, address, phone: _____

Are you currently in litigation for this injury? Yes No Maybe

Explain how the injury or illness occurred: _____

What injuries did you suffer? _____

Have you missed work due to this injury or illness? Yes No If yes, how many days? _____

When was the last day you worked? _____

Have you been examined by another physician? Yes No

If yes, who examined you? _____

What was the doctor's diagnosis? _____

Have you received any treatment prior to visiting this office? Yes No

What treatment did you receive? _____

Have you ever injured this area before? Yes No

If yes, when did this previous injury occur? _____

Did you lose time from work from this previous injury? Yes No

Do you have other injuries or illness that affect your employment? Yes No

If yes, please explain: _____

Do you have a history of absenteeism caused from accidents on the job? Yes No

Have you ever had a Worker's Compensation claim before? Yes No

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

Are your work activities restricted or limited as a result of this accident? Yes No

Since the injury, are your symptoms: improving getting worse remaining the same

Assignment of Payment

My insurance carrier and/or attorney are hereby requested and authorized to pay direct to Donahue Chiropractic any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay Donahue Chiropractic the difference, if any, between the total amount of charges on my account and the amount paid by the insurance carrier and/or attorney. It is further understood that I, the undersigned, agree to pay Donahue Chiropractic the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier and/or attorney refuses to pay my claim.

Patient's signature: _____ Date: _____

Printed name: _____

Witness: _____