DONAHUE CHIROPRACTIC

Worker's Compensation Questionnaire

Employee's Name: _____ Date: _____
Occupation: _____
Employer's Name: _____
Employer's Address: _____
Type of Business: _____
Supervisor: _____ Supervisor #: _____
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 Chiropratic 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: _____