

# Worker's Compensation Questionnaire

**SCHILLINGER  
CHIROPRACTIC  
GROUP**

1050 Northgate Drive  
Suite 1  
San Rafael, CA 94903  
(415) 491-0959

\_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Driver's License Number \_\_\_\_\_

\_\_\_\_\_ Driver's License Issued by what state? \_\_\_\_\_

Patient name: \_\_\_\_\_  Male  Female

Marital status: \_\_\_\_\_ How many children? \_\_\_\_\_ Your daytime phone: \_\_\_\_\_

Name of spouse: \_\_\_\_\_ Spouse's occupation \_\_\_\_\_

Spouse's employer: \_\_\_\_\_ Office phone: \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

Your Group/Individual Health Insurance carrier: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy number: \_\_\_\_\_ Group number: \_\_\_\_\_

Who did you report accident to? \_\_\_\_\_ What is their position? \_\_\_\_\_

**HISTORY** - What were you doing at the time you were injured? Describe the accident in detail: were you bending, walking, running, lifting, etc.) If you were lifting, what object did you lift and how much did it weigh? **Please be specific and give all the details!**

Describe the physical conditions which may have contributed to your present injury: Darkness, faulty equipment, slippery floor, limited space. Distinguish natural hazards from hazards created by other employees such as housekeepers or co-workers:

Did you seek medical help before coming to this office?  Yes  No

If YES, How did you get there?  Someone drove me  Drove myself  Police  Ambulance  Other

Name of Hospital or Clinic you were treated prior to being treated in our office? \_\_\_\_\_

Name of treating doctor: \_\_\_\_\_ Were you examined?  Yes  No

Were X-rays taken?  Yes  No If Yes, what area? \_\_\_\_\_

What treatment was given? \_\_\_\_\_

Were you prescribed any drugs or medication?  Yes  No If Yes, what? \_\_\_\_\_

Did you take them?  Yes  No Where they effective?  Yes  No

Prior to this accident, have you ever had any physical complaints similar to what you have now?  Yes  No

If Yes, please describe: \_\_\_\_\_

Do you have any congenial (from birth) factors which relate to this problem?  Yes  No

If Yes, please describe: \_\_\_\_\_

Have you ever been involved in a motor vehicle accident?  Yes  No

If Yes, please describe your injuries: \_\_\_\_\_

Have you ever been involved in a Workers Compensation claim before?  Yes  No If Yes, please give dates, parts of the body

injured, and type of settlement: \_\_\_\_\_

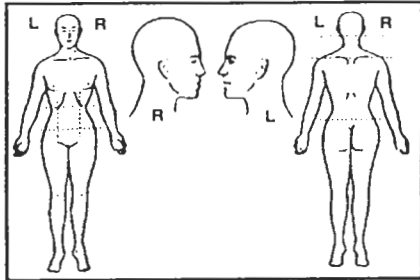
**CURRENT COMPLAINTS**

When did pain begin? When did you first feel it? Was pain intense at first, or did pain that gradually worsen? **Please be specific!**

\_\_\_\_\_

\_\_\_\_\_

Shade Area(s) to indicate location(s) of pain or discomfort.



Indicate your ability to perform the following activities as a result of this injury using codes: **N = Normal L = Limited D = Difficult P = Painful U = Unable**

- |                                   |                             |               |
|-----------------------------------|-----------------------------|---------------|
| ___ Walking short distance        | ___ Bending over forward    | ___ Balancing |
| ___ Standing more than 1 hour     | ___ Coughing or sneezing    | ___ Sleeping  |
| ___ Sitting at a table            | ___ Getting in/out of a car | ___ Stooping  |
| ___ Lying on back                 | ___ Turning over in bed     | ___ Gripping  |
| ___ Lying flat on stomach         | ___ Climbing                | ___ Pushing   |
| ___ Lying on side with knees bent | ___ Kneeling                | ___ Pulling   |
| ___ Reaching                      | ___ Sex activity            |               |

Check the square that best applies to your condition: Symptoms are WORSE in:  A.M.  Mid-day  P.M.  
Symptoms are BETTER in:  A.M.  Mid-day  P.M.

**Work Status** - Have you missed any time at work?  Yes  No If Yes, full time off from \_\_\_\_\_ to \_\_\_\_\_

Part time off from \_\_\_\_\_ to \_\_\_\_\_ Have not been able to work since \_\_\_\_\_

What can't you do at work as a result of this accident? \_\_\_\_\_

**Work Activities** - On the job, I perform the following activities:

- |                |                     |                                |
|----------------|---------------------|--------------------------------|
| ___ Bend/Stoop | ___ Crouch          | ___ Reach above shoulder level |
| ___ Squat      | ___ Kneel           |                                |
| ___ Crawl      | ___ Balancing       | ___ Sitting                    |
| ___ Climb      | ___ Pushing/Pulling |                                |

On the job I lift:

- |                  |                   |
|------------------|-------------------|
| ___ Up to 10 lbs | ___ 35 to 50 lbs  |
| ___ 11 to 24 lbs | ___ 51 to 74 lbs  |
| ___ 25 to 34 lbs | ___ 75 to 100 lbs |

Describe any job activities not listed above: \_\_\_\_\_

**PAYMENT IS EXPECTED AT TIME OF VISIT**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Schillinger Chiropractic Group will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the Schillinger Chiropractic Group will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Signature \_\_\_\_\_ Today's Date \_\_\_\_\_

**For Office Use Only**

Date	Time	Name of Person Contacted	Comments	Initials
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Workers' Compensation Insurance Carrier Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_