

# 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	HOME PHONE		DATE	
ADDRESS				CITY		STATE	ZIP
SOCIAL SECURITY #			AGE	BIRTH DATE	SEX	MARITAL STATUS	NO. OF CHILDREN
EMPLOYER		ADDRESS			BUSINESS PHONE		
OCCUPATION				WHO REFERRED YOU TO OUR OFFICE?			

OCCUPATIONAL HISTORY				
NAME		CHART #	TODAY'S DATE	ACCIDENT DATE
Current Employer: _____				
Current Occupation: _____				
Relevant Prior Employers and Job Information: _____				
Name of employer at the time of injury (if different from current): _____				
Retraining for a new job: _____				
New job's contribution to injury: _____				
Limitations of working as a result of injury: _____				

**What limitations have you experienced as a result of your injury? (choose all that apply)**

<input type="checkbox"/> Cannot use left arm	<input type="checkbox"/> Increased fatigability	<input type="checkbox"/> Unable to lift more than 15 pounds	<input type="checkbox"/> _____
<input type="checkbox"/> Cannot use right arm	<input type="checkbox"/> Lifting exacerbates condition	<input type="checkbox"/> Unable to lift more than 20 pounds	<input type="checkbox"/> _____
<input type="checkbox"/> Cannot use left leg	<input type="checkbox"/> Pain limits amount of movement	<input type="checkbox"/> Unable to lift more than 25 pounds	<input type="checkbox"/> _____
<input type="checkbox"/> Cannot use right leg	<input type="checkbox"/> Cannot sit due to condition	<input type="checkbox"/> Unable to lift more than 50 pounds	<input type="checkbox"/> _____
<input type="checkbox"/> Cannot drive due to condition	<input type="checkbox"/> Unable to lift more than 10 pounds	<input type="checkbox"/> Cannot walk due to condition	<input type="checkbox"/> _____

**Your present job involves:**

<b>Standing for:</b> <input type="checkbox"/> 30 minutes <input type="checkbox"/> 1 hours <input type="checkbox"/> 2 hours <input type="checkbox"/> 3 hours <input type="checkbox"/> 4 hours <input type="checkbox"/> 6 hours <input type="checkbox"/> 8 hours <input type="checkbox"/> >8 hours	<b>Driving for:</b> <input type="checkbox"/> 30 minutes <input type="checkbox"/> 1 hours <input type="checkbox"/> 2 hours <input type="checkbox"/> 3 hours <input type="checkbox"/> 4 hours <input type="checkbox"/> 6 hours <input type="checkbox"/> 8 hours <input type="checkbox"/> >8 hours	<b>Walking for:</b> <input type="checkbox"/> 30 minutes <input type="checkbox"/> 1 hours <input type="checkbox"/> 2 hours <input type="checkbox"/> 3 hours <input type="checkbox"/> 4 hours <input type="checkbox"/> 6 hours <input type="checkbox"/> 8 hours <input type="checkbox"/> >8 hours	<b>Sitting for:</b> <input type="checkbox"/> 30 minutes <input type="checkbox"/> 1 hours <input type="checkbox"/> 2 hours <input type="checkbox"/> 3 hours <input type="checkbox"/> 4 hours <input type="checkbox"/> 6 hours <input type="checkbox"/> 8 hours <input type="checkbox"/> >8 hours	<b>Lifting (pre-injury)</b> <input type="checkbox"/> Less than 5 lbs. <input type="checkbox"/> 05 - 10 lbs. <input type="checkbox"/> 10 - 15 lbs. <input type="checkbox"/> 15 - 20 lbs. <input type="checkbox"/> 20 - 25 lbs. <input type="checkbox"/> 25 - 40 lbs. <input type="checkbox"/> 40 - 50 lbs. <input type="checkbox"/> >50 lbs.	<b>Lifting (post-injury)</b> <input type="checkbox"/> Less than 5 lbs. <input type="checkbox"/> 05 - 10 lbs. <input type="checkbox"/> 10 - 15 lbs. <input type="checkbox"/> 15 - 20 lbs. <input type="checkbox"/> 20 - 25 lbs. <input type="checkbox"/> 25 - 40 lbs. <input type="checkbox"/> 40 - 50 lbs. <input type="checkbox"/> >50 lbs.
<b>Typing</b> <input type="checkbox"/> 30 minutes <input type="checkbox"/> 1 hours <input type="checkbox"/> 2 hours <input type="checkbox"/> 3 hours <input type="checkbox"/> 4 hours <input type="checkbox"/> 6 hours <input type="checkbox"/> 8 hours <input type="checkbox"/> >8 hours	<b>Using Mouse</b> <input type="checkbox"/> 30 minutes <input type="checkbox"/> 1 hours <input type="checkbox"/> 2 hours <input type="checkbox"/> 3 hours <input type="checkbox"/> 4 hours <input type="checkbox"/> 6 hours <input type="checkbox"/> 8 hours <input type="checkbox"/> >8 hours	<b>Grasping</b> <input type="checkbox"/> 30 minutes <input type="checkbox"/> 1 hours <input type="checkbox"/> 2 hours <input type="checkbox"/> 3 hours <input type="checkbox"/> 4 hours <input type="checkbox"/> 6 hours <input type="checkbox"/> 8 hours <input type="checkbox"/> >8 hours	<b>Crawling</b> <input type="checkbox"/> 30 minutes <input type="checkbox"/> 1 hours <input type="checkbox"/> 2 hours <input type="checkbox"/> 3 hours <input type="checkbox"/> 4 hours <input type="checkbox"/> 6 hours <input type="checkbox"/> 8 hours <input type="checkbox"/> >8 hours	<b>Climbing</b> <input type="checkbox"/> 30 minutes <input type="checkbox"/> 1 hours <input type="checkbox"/> 2 hours <input type="checkbox"/> 3 hours <input type="checkbox"/> 4 hours <input type="checkbox"/> 6 hours <input type="checkbox"/> 8 hours <input type="checkbox"/> >8 hours	<input type="checkbox"/> Repetitive Motion  <input type="checkbox"/> Fine manipulation, pushing, pulling, torquing with hands

Have you missed any work as a result of your condition?  Yes  No  
 If yes, how many days did you miss? \_\_\_\_\_

Are you currently receiving worker's compensation?  Yes  No  
 Your last full day of work was: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Have you had any prior work injuries?  Yes  No

Have you received a prior workers' comp award?  Yes  No

**Work Conditions:**

Rest breaks \_\_\_\_\_ Type of surface worked on \_\_\_\_\_  
 % of workday indoors \_\_\_\_\_ Exposure to... \_\_\_\_\_  
 % of workday outdoors \_\_\_\_\_ Other requirements \_\_\_\_\_

I understand that the information I have provided above is current and complete to the best of my knowledge.

## MODE OF INJURY

NAME	CHART #	TODAY'S DATE	DATE OF ONSET	TIME OF INJURY
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**Complete this section if injuries are a result of a work related accident.**

My injury occurred while I was... <input type="checkbox"/> Carrying an object and lost my balance <input type="checkbox"/> Driving <input type="checkbox"/> Lifting an object <input type="checkbox"/> Struck by a falling object _____ <input type="checkbox"/> Engaged in a repetitive motion activity _____ <input type="checkbox"/> Other _____ _____ _____	Did you report this incident in writing at work? <input type="checkbox"/> Yes <input type="checkbox"/> No Person reported to: _____    Date reported: _____ Did you see another health care provider for treatment related to this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**If you were injured by lifting, please complete all of the items which apply in the box below.**

<b>I was lifting the object:</b> <input type="checkbox"/> from the floor <input type="checkbox"/> from a surface over my head <input type="checkbox"/> from a surface about waist high	<b>While I was lifting, I:</b> <input type="checkbox"/> had my back straight <input type="checkbox"/> had my waist bent <input type="checkbox"/> was twisted to the side	<b>The object I was lifting was about:</b> <input type="checkbox"/> 2 - 5 pounds <input type="checkbox"/> 20 - 25 pounds <input type="checkbox"/> 5 - 10 pounds <input type="checkbox"/> 25 - 50 pounds <input type="checkbox"/> 10 - 15 pounds <input type="checkbox"/> More than 50 pounds <input type="checkbox"/> 15 - 20 pounds	<b>The pain I felt immediately after the injury was:</b> <input type="checkbox"/> a dull ache <input type="checkbox"/> a sharp pain with radiation of symptoms <input type="checkbox"/> a grabbing feeling <input type="checkbox"/> a popping feeling <input type="checkbox"/> a sharp pain in one spot
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**If you were injured by falling, please complete the items in the box below.**

<b>I fell:</b> <input type="checkbox"/> from a surface 2-4 feet high <input type="checkbox"/> from a surface 4-6 feet high <input type="checkbox"/> from a surface 6-8 feet high <input type="checkbox"/> from a surface higher than 8 feet <input type="checkbox"/> onto surface I was walking on	<b>When I fell I hit my:</b> <input type="checkbox"/> Back <input type="checkbox"/> Right hand/wrist <input type="checkbox"/> Left elbow <input type="checkbox"/> Head <input type="checkbox"/> Right elbow <input type="checkbox"/> Left knee <input type="checkbox"/> Face <input type="checkbox"/> Right knee <input type="checkbox"/> Left hand/wrist <input type="checkbox"/> Tail bone	<b>The surface I fell on can be described as:</b> <input type="checkbox"/> Containing an object that caused the fall <input type="checkbox"/> Icy <input type="checkbox"/> Slick due to liquid <input type="checkbox"/> Wet <input type="checkbox"/> Uneven carpet	<b>I landed on:</b> <input type="checkbox"/> Back <input type="checkbox"/> Left side <input type="checkbox"/> Knees <input type="checkbox"/> Right side <input type="checkbox"/> Rear end <input type="checkbox"/> Stomach <input type="checkbox"/> Outstretched arms
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**Complete this section if your injuries were NOT work related or auto accident related.**

<b>My injury occurred when I:</b> <input type="checkbox"/> coughed or sneezed <input type="checkbox"/> straightened from bending <input type="checkbox"/> slipped and fell <input type="checkbox"/> looked over my shoulder <input type="checkbox"/> twisted at the waist	<b>Injury occurred at:</b> <input type="checkbox"/> Home <input type="checkbox"/> Retail store <input type="checkbox"/> Work <input type="checkbox"/> Mall <input type="checkbox"/> Supermarket
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### WORKERS COMPENSATION PATIENT WAIVER

As a workers compensation patient receiving services at Barley Family Health Care & Rehabilitation, I understand it is my responsibility to supply this office with approval for treatment from my employer and workers compensation insurance carrier. I also understand that I need to provide the name and address of the workers compensation insurance carrier to Barley Chiropractic.

In the event that my employer or the insurance carrier denies my claim I will assume full responsibility for payment to this office.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (If a minor, parent's or guardian's signature)

Doctor's Signature: \_\_\_\_\_ Date \_\_\_\_\_