



Chugach Chiropractic Clinic LLC

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Worker's Compensation Questionnaire

SECTION 1	1. Employee's Name (Last, First, Middle Initial)		2. Insurer Claim Number	3. Injury Date
	4. Address		5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	6. Social Security Number
	City	State	Zip Code	Telephone
	8. Employer		9. Insurer	
	10. Address		11. Address	
	City	State	Zip Code	Telephone
SECTION 2	12. Date Last Worked	13. Was Body Part Injured Before? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when and describe:		
	14. Describe Injury and Tell How it Happened:			
	15. Have You Seen any Other Doctor for this Injury? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, list name and address:		16. Hospitalized as Inpatient? <input type="checkbox"/> No <input type="checkbox"/> Yes Name of Hospital:	

Was your accident directly related to your work? Yes No

Briefly describe the events that occurred just before and during your accident: _____

Did you report your accident to your employer? Yes No

Did accident render you unconscious? Yes No If yes, for how long: _____

Please describe how you felt immediately after the accident: _____

Describe any treatment you received: _____

Were x-rays taken? Yes No

Was medication prescribed? Yes No If yes, what type: _____

Are your work activities restricted as a result of this injury? Yes No

Indicate the symptoms that are a result of this accident:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Arms / Shoulder Pain | <input type="checkbox"/> Upper / Mid Back Pain |
| <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numb Hands / Fingers | <input type="checkbox"/> Lower Back Pain |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Back Stiffness |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Tension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Numb Feet / Toes |
| <input type="checkbox"/> Ears Ringing / Buzzing | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Stomach Upset / Nausea | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Leg Pain | _____ |

Is your condition getting worse? Yes No