WORKER'S COMPENSATION QUESTIONNAIRE

Date ______

Dear Patient: This information is considered confidential and necessary in order for our office to handle your workman's compensation claim in an expeditious and orderly fashion. All information is vital and pertinent in order for our office/staff to have a complete understanding of your present complaints and condition. Please be as accurate and legible as possible while completing this form. Thank you.

Name: ______ Marital Status: S M Other Sex M F

Address: ______ DOB: ______ SSN: ______

City: ______ State: ______ Zip: ______ Home Phone: ______

How were you referred to this office: ______

Occupation: ______ Spouse's First Name: ______

Business Phone: ______ Spouse's SSN: ______

Company Name: ______ Spouse's Employer: ______

Business Phone: ______ Location: ______

Please explain in detail how your accident happened: ______

______

______

Have you retained an attorney: ☐ Yes ☐ No Litigation: ☐ Yes ☐ No ☐ Maybe

Attorney name: ______

Attorney address: ______

Give time and date present injury occurred: ______ a.m. ______ p.m. ______ 20 ______

Where did you feel pain immediately after the accident? ______

Did you return to work? ☐ Yes ☐ No

Did you consult any other doctor? ☐ Yes ☐ No

If so, give doctor's name: ______ ☐ D.N. ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S.

Doctor's diagnosis: ______

What treatments did you receive? ______

Have you ever injured this area before? ☐ Yes ☐ No If so, when: ______

If injured before, did you lose time from work? ☐ Yes ☐ No

If you lost time from work with injuries prior to this injury,
give name of doctor or doctors consulted:

______

______

Naprapathic Medicine of New Mexico

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QUESTIONNAIRE CONTINUED ON NEXT PAGE

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WORKMAN'S COMPENSATION QUESTIONNAIRE, CONTINUED

Do any other diseases or accidents affect your employment? ☐ Yes ☐ No

If so, explain: ______________________________

____

____

In your work, do you have to favor any part of your body? ☐ Yes ☐ No

If so, explain: ______________________________

____

____

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

Have you ever had a workman's compensation claim before? ☐ Yes ☐ No

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

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

Since the accident are your symptoms: ☐ improving? ☐ the same? ☐ getting worse?

Patient signature: ______________________ Date: ______________

If for any reason my employer does not approve this injury as a Workman's Comp., I am responsible for payment of all services rendered in full immediately.

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