MARTIN CHIROPRACTIC
225 E. BUENA VISTA STREET
BARSTOW, CALIFORNIA 92311

WORKERS COMPENSATION ACCIDENT QUESTIONNAIRE

NAME _____ DATE _____ TIME (of first appointment) _____

Date of injury _____ Time of injury _____ (Indicate AM/PM)

Place/Address where injury occurred _____

_____

What type of work were you doing? _____

How long have you worked for this employer? _____

Did you notify your employer of this injury? Yes _____ No _____

Did you lose any time from work? Yes _____ No _____; If yes, how much time

From _____ To _____

Have you returned to work? Yes _____ No _____

Are you doing the same kind of work? Yes _____ No _____; If no, please state the restrictions _____

_____

Description of accident (Please be specific) _____

_____

_____

_____

Did you fall? Yes _____ No _____; how far? _____

Did you strike any objects? Yes _____ No _____; what object? _____

Were you unconscious? Yes _____ No _____; how long? _____

When did you notice the onset of symptoms? _____

How did you leave the scene of the accident? _____

_____

Did you require assistance in leaving? Yes _____ No _____

Were you taken to: Hospital Yes _____ No _____

Private Doctor Yes _____ No _____

Went Home Yes _____ No _____

Returned to Work Yes _____ No _____

Name and address of hospital or current treating doctor _____

_____

_____

Were X-rays taken? Yes _____ No _____; what part was X-rayed? _____

_____

Did you receive a physical examination? Yes _____ No _____

Were any laboratory tests or special tests done? Yes _____ No _____; what type?

_____

_____

Have you received any prior treatment for this injury? Yes _____ No _____; what type?

_____

_____

Did you receive any medications for this condition? Yes _____ No _____; what kind?

_____

_____

What were you told was wrong with you? _____

_____

When was the first time you saw a doctor for this condition? _____

Names of other doctors seen, in order, when and for how long _____

_____

_____

_____

PRIOR HISTORY

Have you had any surgeries prior to this injury? Yes _____ No _____; if yes, in what area and when? _____

_____

_____

Have you ever broken any bones? Yes _____ No _____; if yes, in what are a and when?

_____

Have you ever had a prior work injury? Yes _____ No _____; in what area? _____

_____ Date of prior injury _____

Have you ever had a prior injury or illness in the area of your current condition?

Yes _____ No _____; which area _____

Do you have any physical impairment due to any previous accident or disease?

Yes _____ No _____; which area _____

Have you ever been in any automobile accident? Yes _____ No _____; if so, when?

_____

Have you ever had any personal injury case or suit? Yes _____ No _____; if yes, please be specific _____

_____

PERSONAL INFORMATION

Your Height (approximate) _____

Your weight (approximate) _____

Your place and date of birth _____

Mother's age and state of health _____

Father's age and state of health _____

If relative is deceased, please indicate the cause _____

Number of brothers, ages, and state of health of each _____

_____

_____

Number of sisters, ages, and state of health of each _____

_____

_____

Are you married? Yes _____ No _____; Anniversary date _____

Number of sons, ages, and state of health of each _____

_____

Number of daughters, ages, and state of health of each _____

_____

Do you drink alcohol? Yes _____ No _____; (if occasionally, please indicate)

_____

Do you drink coffee? Yes _____No _____; if yes, how many cups a day and if occasionally, please indicate _____

History of drug use and reason for usage _____

_____

_____

Hobbies & frequency performed activities_____

_____

OCCUPATIONAL HISTORY

Name of high school and year graduated _____

_____

Name of college and year graduated _____

_____

Course of occupation; in order, name the place of employment, year employed, and job title you held. (GIVE A DETAILED DESCRIPTION OF JOB WHICH LED TO INJURY)

1. _____

_____

_____

2. _____

_____

_____

3. _____

_____

_____

4. _____

_____

_____

(Please use back of this questionnaire if you need additional room.)

MILITARY HISTORY

Branch _____

Years enlisted _____

Years discharged _____

Injuries incurred, if any, explain _____

_____

LOCATION OF DISCOMFORT:

Please indicate by an asterisk (*) the major areas of discomfort. Please indicate by a checkmark (✓) the areas of less discomfort, areas that are sore and tender.

Right Side	Left Side	Both Side		Right Side	Left Side	Both Side	
( )	( )	( )	Head	( )	( )	( )	Between shoulder blades
( )	( )	( )	Face	( )	( )	( )	Shoulder blade
( )	( )	( )	Mouth	( )	( )	( )	Mid-back
( )	( )	( )	Jaw	( )	( )	( )	Low back
( )	( )	( )	Forehead	( )	( )	( )	Chest
( )	( )	( )	Back of head	( )	( )	( )	Ribs
( )	( )	( )	Neck	( )	( )	( )	Abdomen
( )	( )	( )	Between neck And shoulder	( )	( )	( )	Lower abdomen
( )	( )	( )	Shoulder	( )	( )	( )	Hip
( )	( )	( )	Upper arm	( )	( )	( )	Buttocks
( )	( )	( )	Arm	( )	( )	( )	Front of thighs
( )	( )	( )	Elbow	( )	( )	( )	Back of thighs
( )	( )	( )	Forearm	( )	( )	( )	Knee
( )	( )	( )	Wrist	( )	( )	( )	Calf
( )	( )	( )	Hand	( )	( )	( )	Ankle
( )	( )	( )	Fingers/thumb	( )	( )	( )	Foot
( )	( )	( )	Other _____	( )	( )	( )	Toe

Remarks _____

_____

DESCRIPTION, QUANTITY, AND FREQUENCY OF DISCOMFORT:

DESCRIPTION OF DISCOMFORT:

( ) Ache ( ) Dull ( ) Sharp ( ) Tingle

( ) Numb ( ) Burning ( ) Throbbing ( ) Pain

QUANTITY OF DISCOMFORT:

( ) Minimal ( ) Slight ( ) Moderate ( ) Severe

FREQUENCY OF DISCOMFORT:

( ) Rare ( ) Occasional ( ) Intermittent ( ) Frequent

( ) Constant

Is the pain worse: ( ) Morning ( ) Evening

( ) Afternoon ( ) Basically the same all of the time

Does the pain interfere with your work? Yes _____ No _____: how? _____

_____

_____

_____

Does the pain or discomfort seem to be ( ) getting better, ( ) getting worse; ( ) about the same intensity.

Are there any positions that make the pain worse, and if so, what positions? _____

_____

_____

What makes the pain or discomfort feel worse? (Activities) _____

_____

IN YOUR OWN WORDS, DESCRIBE WHAT HURTS, WHERE IT HURTS, HOW MUCH IT HURTS, AND HOW OFTEN IT HURTS _____

_____

_____

_____

_____

_____

_____

_____

HISTORY OF PRIOR MAJOR INJURY, ILLNESS, OR SURGERY

Date(s) Treating Doctor(s) For What Condition?

Have you ever had a workers compensation case or suit? Yes _____ No _____

If so, please explain when, where, how, etc. _____