WORKMAN'S COMPENSATION QUESTIONNAIRE

1 PERSONAL INFORMATION

Patient Name: _____ Phone _(_____)_____

Address: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____

Birthdate: _____ Age: _____ Sex: M F Height: _____ Weight: _____ S/S#:_____

❒Single ❒Married ❒Divorced ❒Widow/Widower

2 EMPLOYER INFORMATION

Employer's Name: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____Phone _(_____)_____

Type of Business: _____ Your Occupation: _____

Name of Compensation Carrier: _____ Phone _(_____)_____

Address of Carrier: _____

(street) (city) (state) (zip)

Adjuster name.: _____

3 INSURANCE INFORMATION

Name of Insured: _____ Relationship to patient: _____

Birth Date: _____ SS#: _____ Date employed: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Co: _____Phone: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Group#: _____ ID#: _____

How much is your deductible? _____ How much of your deductible have you met? _____

Maximum annual benefit? _____

4 ATTORNEY

Have you engaged the services of an attorney? ❒No ❒Yes If yes, please fill in the following:

Attorney: _____

Address: _____

City: _____ State: __ Zip: _____ Phone: _____

CHCC Name: _____ Date: _____ Signature: _____

WORKMAN'S COMPENSATION QUESTIONNAIRE

5 PRE-INJURY ACTIVITIES

Please check the sports activities you normally enjoy engaging in:

❒Water skiing
❒Snow skiing
❒Martial Arts
❒Weight lifting
❒Soccer
❒Jogging
❒Surfing
❒Gardening
❒Aerobics
❒Football
❒Backpacking
❒Scuba Diving
❒Golf
❒Tennis
❒Volleyball
❒Long Walks
❒Biking
❒Windsurfing
❒Other _____

Are you currently able to perform the above? ❒Yes ❒No Please explain: _____

6 PAST INJURY/TRAUMA HISTORY

Injury(ies) and Date of injury(ies):

INJURY	DATE

WORKMAN'S COMPENSATION QUESTIONNAIRE

7 SOCIAL HISTORY

Marital Status: ❒Single ❒Married ❒Divorced ❒Widow/Widower Number of children: _____ How many living at home? _____

Do you smoke cigarettes? ❒Yes ❒No Number of packs per day? _____ For how many years? _____

Do you drink alcohol? ❒Yes ❒No If Yes, check one: ❒Rarely ❒Socially ❒Occasionally ❒Moderately ❒Heavily

Do you take recreational drugs? ❒Yes ❒No If Yes, what kind? _____

If you are a female, is there a chance that you are pregnant? ❒Yes ❒No If Yes, when is your due date? _____

8 CURRENT INJURY INFORMATION *(for this inury)*

Injury(ies) and Date of injury(ies):

INJURY	DATE

Do you feel that your accident has resulted in the following (please check the ones below that apply):

❒Nausea	❒Headaches	❒Tingling	❒Fear of driving
❒Vomiting	❒Nervousness	❒Diarrhea	❒Weakness
❒Dizziness	❒Shakiness	❒Skin Rash	❒Irritability
❒Numbness	❒Depression	❒Loss of appetite	❒Blurred Vision
❒Insomnia	❒Ringing in ears	❒Increase in appetite	❒Loss of Smell
❒Bowel or Bladder Problems	❒Loss of Memory	❒Loss of Taste	❒Altered Sexual Activity
❒Loss of Consciousness	❒Paralysis	❒Changes in Taste	❒Tremors
❒Headaches	❒Cough	❒Flu	❒Chest Pains
❒Pneumonia	❒Chills	❒Fever	❒Shortness of Breath
❒Palpitations	❒Leg Swelling	❒Leg Pains	❒Painful Urination
❒Abdominal Pain	❒Blood in Stool	❒Loss of Weight	❒Gain of Weight

❒Other _____

Check the things you find difficult doing since your accident:

❒Working	❒Driving	❒Sitting for long periods	❒Household duties
❒Lifting	❒Writing	❒Standing for long periods	
❒Walking	❒Climbing stairs	❒Recreational activities	❒Other _____

Are the above complaints getting better or worse? (Check one): ❒Better ❒Worse

Just before the accident, were you experiencing any of the above symptoms or problems? (Please list which ones):

_____

_____

_____

9 MUSCULO-SKELETAL (neck, back, leg, etc.) *{ detail information that only pertains to the current injury }*

#1 PAIN COMPLAINT:

1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____

5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe

6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days

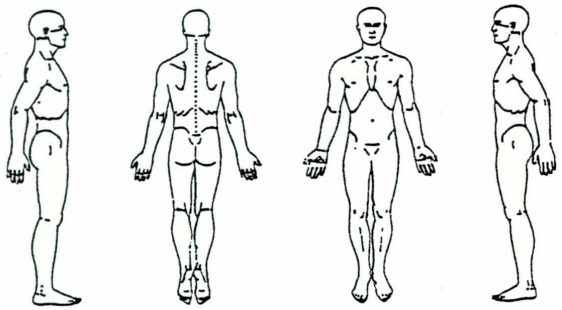
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____

10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



Draw/Shade the affected areas on the image(s) above to indicate your pain locations. Please use arrows to show the direction that the pain flows to or from these areas.

Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

#2 PAIN COMPLAINT:

1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____

5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe

6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days

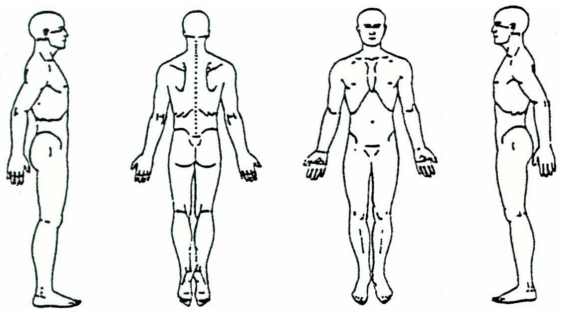
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____

10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



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Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

MUSCULO-SKELETAL (neck, back, leg, etc.) *{ detail information that only pertains to the current injury }*

#3 PAIN COMPLAINT:

1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____

5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe

6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days

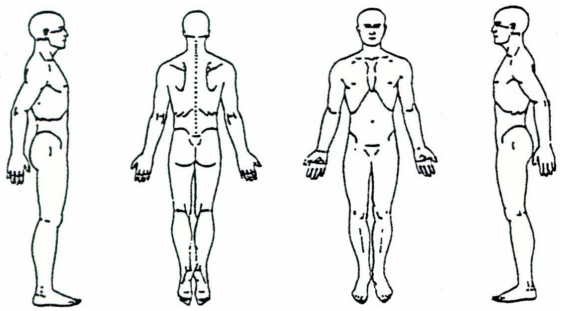
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____

10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



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Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

#4 PAIN COMPLAINT:

1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____

5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe

6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days

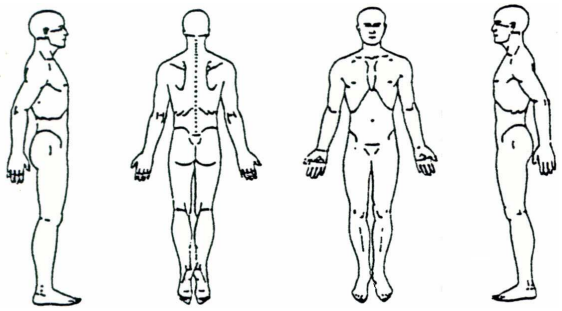
8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____

10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

11. What treatment have you already received for this condition?
❑ Medications ❑ Surgery ❑ Physical therapy ❑ Chiropractic services ❑ None ❑ Other_____



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Please circle the accurate pain level below (1-low; 10-high)
1 2 3 4 5 6 7 8 9 10

9 MUSCULO-SKELETAL (neck, back, leg, etc.) *{ detail information that only pertains to the current injury }*

#5 PAIN COMPLAINT:

1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____

5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe

6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days

8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____

10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

11. What treatment have you already received for this condition?
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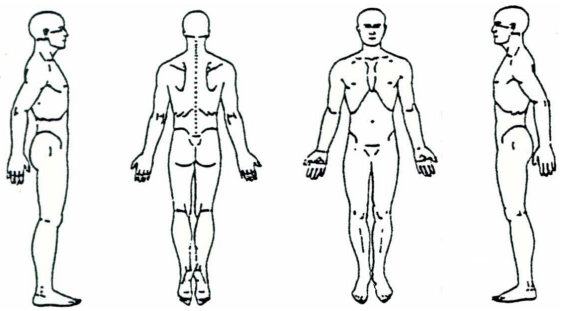

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Please RATE YOUR PAIN!
Please circle the accurate pain level below (1-low; 10-high)
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#6 PAIN COMPLAINT:

1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
❑ Tingling	❑ Burning	❑ Stiffness	❑ Pulling

4.Radiation: Does the pain go to other parts of the body?
❑ Yes ❑ No Where?_____

5. Degree: What is the degree of your pain?
❑ Mild ❑ Moderate ❑ Severe

6. Frequency: How often do you have this pain?
❑ Occasional ❑ Intermittent ❑ Frequent ❑ Constant

7. Duration: How long does the pain last? ___Min. ___ Hrs.____ Days

8. What makes the pain worse?

❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
❑ Aspirin/medication ❑ Other_____

10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

11. What treatment have you already received for this condition?
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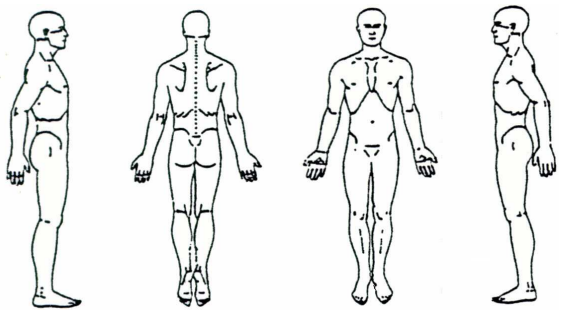

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9 MUSCULO-SKELETAL (neck, back, leg, etc.) *{ detail information that only pertains to the current injury }*

#7 PAIN COMPLAINT:

1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
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❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

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10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

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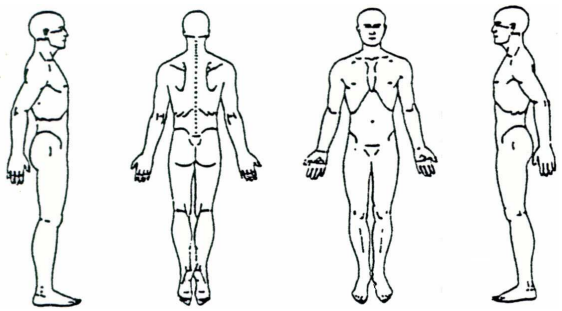

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#8 PAIN COMPLAINT:

1. When did your symptoms appear?
Date of onset:_____ Was it: ❑ Sudden ❑ Gradual

2. Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

3. Describe your pain/complaint:

❑ Dull	❑ Sharp	❑ Ache	❑ Stabbing
❑ Deep	❑ Superficial	❑ Spasm/tension	❑ Numbness
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❑ Standing	❑ Sitting	❑ Bending	❑ Twisting
❑ Walking	❑ Lifting	❑ Sleeping	❑ Heat
❑ Cold	❑ Stooping	❑ Sex	❑ Other

9. What makes the pain better?
❑ Sitting ❑ Standing ❑ Rest ❑ Heat ❑ Cold
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10. Does it interfere with your :
❑ Work ❑ Sleep ❑ Daily routine ❑ Recreation

11. What treatment have you already received for this condition?
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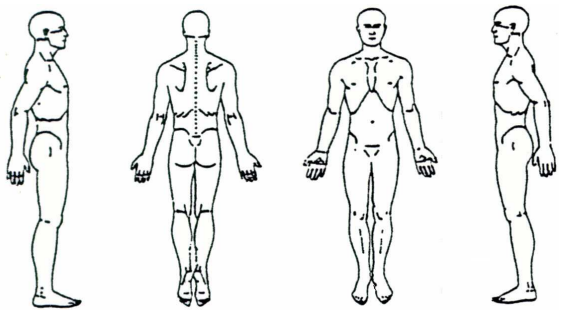

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WORKMAN'S COMPENSATION QUESTIONNAIRE

ACCIDENT INJURY

1. When did you start working there? _____
2. Date injured _____ Hour _____ AM / PM Last Date Worked: _____ Are you off work? ❒Yes ❒No
3. Previous Workers' Compensation Injury ❒Yes ❒No Describe injury: _____
4. Accident reported to employer? ❒Yes ❒No Name of person reported accident to _____ Date: _____
5. Injured at (address): _____

   (street) (city) (state) (zip)
6. Length of time worked there prior to accident: _____
7. Type of work being done at time of injury: _____

   7a. _____

   _____

   _____

   _____

   7b. Did you continue working? ❒Yes ❒No If No, why not? _____

   _____

   _____
8. a) Was there a fall? ❒Yes ❒No If Yes, how far?

   b) Were you knocked out? ❒Yes ❒No If yes, for how long? _____

   c) Did you feel immediate pain? ❒Yes ❒No If Yes, where?

	Left/Right	**Left/Right**
❒Head	❒/❒Shoulders	❒/❒Buttocks
❒Neck	❒/❒Arms	❒/❒Hips
❒Upper/Mid Back	❒/❒Elbows	❒/❒Thighs
❒Lower Back	❒/❒Forearms	❒/❒Knees
❒Pelvis	❒/❒Wrists	❒/❒Legs
❒Chest/Rib Cage	❒/❒Hands	❒/❒Ankles
❒Abdomen		❒/❒Feet
❒Other _____		

   d) What parts of the body were hurt? _____

   e) Did any part of the body hit any surface? _____
9. In your own words, briefly describe how the accident happened: _____

   _____

   _____

   _____
10. Was the accident witnessed? ❒Yes ❒No If Yes, by whom? _____
11. Did your supervisor witness the accident? ❒Yes ❒No
12. Name of your supervisor _____
13. Did he/she offer to send you for medical care? ❒Yes ❒No

    ❒Other _____
14. Prior to this accident, have you ever had any of the physical complaints similar to what you have now? ❒Yes ❒No ❒Don't Know

    If Yes, please describe: _____
15. Were these similar complaints the results of a previous accident or accidents? ❒Yes ❒No ❒Don't Know

    If Yes, please describe: _____

WORKMAN'S COMPENSATION QUESTIONNAIRE

JOB SINCE INJURY

Did you miss any days at work? ❒Yes ❒No How many days? _____ Dates: _____

For how long? _____ Are you currently working with the same company? ❒Yes ❒No At regular duties? ❒Yes ❒No

Due to the injury do you have pain when you perform these duties? ❒Yes ❒No

If at modified duties, please list restrictions: _____

_____

If working with a different company, what is the name? _____

What duties do you perform? _____

_____

When did you start working there? _____

If you have had other employers since your injury, please list them:

_____

_____

If you are presently not working, please check the one statement which best explains your reason for not working:

1. ❒ Unable to work
2. ❒ You were terminated (When? _____)
3. ❒ Unable to find work
4. ❒ You are on maternity leave
5. ❒ You are retired
6. ❒ You are on a physician-authorized disability leave (Dates: _____)
7. ❒ You are currently performing or waiting for vocational rehab
8. ❒ You are waiting for a new job assignment with your present employer
9. ❒ You are a seasonal worker and able to perform work, but it is now off season
10. ❒ Other (please explain): _____

_____

CHCC Name: _____ Date: _____ Signature: _____

WORKMAN'S COMPENSATION QUESTIONNAIRE

HISTORY OF TREATMENTS FOR THIS INJURY

1. Are you: ( ) Improved ( ) Unchanged ( ) Getting Worse

2. What types of medicines are you taking? (include over-the-counter medications) _____

_____

_____

Do these medicines help? ❒Yes ❒No ❒Don't know

3. Have you had physical therapy? ❒Yes ❒No If Yes, how often? ❒Daily ❒Every Other Day ❒Several Times a Week ❒Weekly ❒Every Other Week ❒Monthly ❒Other _____

4. Does the physical therapy help? ❒Yes ❒No ❒Don't know

What parts of the body were treated with therapy? _____

What kind of treatment/medicine? _____

5. Were X-rays taken? ❒Yes ❒No Did you receive any other tests? ❒Yes ❒No Please describe: _____

_____

6. What other doctors have you seen for this accident? (Please fill in the table below)

NAME	ADDRESS	FROM (DATE)	TO (DATE)	WHO REFERRED YOU	# OF TREATMENTS

7. Are you under a doctor's care now? ❒Yes ❒No If Yes, Doctor's Name: _____

Address: _____ Date first seen: _____

8. Type of treatment: ❒Hot Packs ❒Cold Packs ❒Ultrasound ❒Electrical Stimulation ❒Exercises ❒Chiropractic Adjustments ❒Other _____ How many times per week? _____ For how long? _____

9. Current treatment and current medications (Please fill in the table below):

TREATMENT	MEDICATIONS

10. Any future appointments? ❒Yes ❒No If Yes, when? _____

11. Is the treatment helping? ❒Yes ❒No

12. Where did you go for medical attention? _____ Doctor's Name: _____

13. What was done by the doctor? ❒Exam ❒CT Scan ❒Medications ❒X-rays ❒Physical Therapy

14. What areas were X-rayed?

	Left/Right	Left/Right
❒Head	❒/❒Shoulders	❒/❒Buttocks
❒Neck	❒/❒Arms	❒/❒Hips
❒Upper/Mid Back	❒/❒Elbows	❒/❒Thighs
❒Lower Back	❒/❒Forearms	❒/❒Knees
❒Pelvis	❒/❒Wrists	❒/❒Legs
❒Chest/Rib Cage	❒/❒Hands	❒/❒Ankles
❒Abdomen		❒/❒Feet
❒Other _____		

WORKMAN'S COMPENSATION QUESTIONNAIRE

PAST MEDICAL HISTORY

1. Please check any illness that you have had or currently have:

❒High Blood Pressure	❒Seizures	❒Liver Disease	❒Arthritis	❒Heart Problem	❒Alcoholism
❒Rheumatoid Arthritis	❒Thyroid	❒Gout	❒Ulcers	❒Diabetes	❒Heart Attack/Stroke
❒Pain with Chewing	❒Heart Disease	❒HIV/Aids	❒Cancer	❒Skin Problems	❒Ear Problems
❒Popping in Jaws	❒Eye Problems	❒Sinus Problems	❒Chest Pain	❒Prostate Problems	❒Hormonal Problems
❒Nervous Illnesses	❒Mental Illnesses	❒Joint Problems	❒Psychiatric Care	❒Infectious Disease	

❒Received a Medical Discharge from the Armed Forces

2. Please indicate type and date of any previous accident or injury (excluding this injury) you have ever had including falls, sports injuries, auto accidents and prior work-related injuries:

Type Of Accident	Body Part Injured	Date	Time Off Work Or School	Did You Fully Recover? (Y/N)	If Yes, What Date?

3. What complaints do you still have from the above-listed injuries?

a. _____

b. _____

c. _____

4. Did you ever receive a permanent disability settlement? ❒Yes ❒No If Yes, when? _____

5. Please list any surgeries:

Date of Surgery	Reason for Surgery	Date Released

6. Please list any hospitalization:

Date Hospitalized	Reason Hospitalized	Date Released

7. Do you have any allergies, including skin allergies to medication or food? ❒Yes ❒No If Yes, what type or to what? _____

_____

_____

CHCC Name: _____ Date: _____ Signature: _____

WORKMAN'S COMPENSATION QUESTIONNAIRE

JOB DESCRIPTION

Occupation: _____ First Day on the Job: _____

Days per Week: _____ Hours per Day: _____ General Job Description: _____

_____

In an 8-hour workday circle the number of hours you were required to perform each of the activities below:

Activity	# of hours performing the activity							
Sitting	1	2	3	4	5	6	7	8
Standing	1	2	3	4	5	6	7	8
Walking	1	2	3	4	5	6	7	8

Please place an "X" in the appropriate boxes that describe the regularity with which you perform the following actions (In terms of an 8-hour workday, "occasionally" means up to 33%; "frequently" means 34% to 66%; "continuously" means 67% to 100% of the day):

ACTION	FREQUENCY			
	Never	Occasionally	Frequently	Continuously
Lifting				
Up to 10 pounds				
11 to 24 pounds				
25 to 34 pounds				
35 to 50 pounds				
51 to 74 pounds				
75 to 100 pounds				
Lifting with Carrying				
Up to 10 pounds				
11 to 24 pounds				
25 to 34 pounds				
35 to 50 pounds				
51 to 74 pounds				
75 to 100 pounds				

What is the heaviest object you lift? _____ How much does it weigh? _____

How many times per day do you lift it? _____

Do you have to bend over while doing any lifting? ❒Yes ❒No

Are your feet used for repetitive movements, such as in operating foot controls? ❒Yes ❒No

Do you use your hands for repetitive actions, such as:

	SIMPLE GRASPING	FIRM GRASPING	FINE MANIPULATING
Right Hand	❒Yes ❒No	❒Yes ❒No	❒Yes ❒No
Left Hand	❒Yes ❒No	❒Yes ❒No	❒Yes ❒No

Are you required to work on unprotected heights? ❒Yes ❒No If Yes, please describe: _____

_____

Are you required to be around moving machinery? ❒Yes ❒No If Yes, please describe: _____

_____

Are you exposed to marked changes in temperature and humidity? ❒Yes ❒No If Yes, please describe: _____

_____

Are you required to drive automotive equipment? ❒Yes ❒No If Yes, please describe: _____

_____

Are you exposed to dust, fumes and/or gases? ❒Yes ❒No If Yes, please describe: _____

_____

WORKMAN'S COMPENSATION QUESTIONNAIRE

JOB DESCRIPTION (cont.)

Please list any additional comments: _____

_____

On the job I perform the following activities:

ACTION	FREQUENCY			
	Never	**Occasionally**	**Frequently**	**Continuously**
Bend/stoop				
Squat				
Crawl				
Crouch				
Kneel				
Balancing				
Climb				
Reach above shoulder level				
Pushing/Pulling				
Grasping with hands				

Please identify the activities that apply to your job at the time of your injury and in the blank next to it write the percentage (100%, 80%, 50%, etc.) of the activity was performed during your workday shift.

Hands at / above shoulders	_____%	Repetitive movements	_____%
Long standing	_____%	Squatting	_____%
Frequent bending	_____%	Stooping	_____%
Holding difficult position	_____%	Twisting	_____%
Vibrating tools / machines	_____%	Lifting, repetitively, _____ lbs	_____%
Climbing driving	_____%	Lifting, maximum, _____ lbs	_____%
Lifting while bent at waist	_____%	Pushing, maximum _____ lbs	_____%
Fine manipulation	_____%	Pushing, repetitively _____ lbs	_____%
Long walking	_____%	Pulling, repetitively _____ lbs	_____%
Long sitting	_____%	Pulling, maximum _____ lbs	_____%

WORKMAN'S COMPENSATION QUESTIONNAIRE

PATIENT AGREEMENT

As a courtesy to our patients, ***Comprehensive Health and Chiropractic Centre*** is set up to utilize direct payment from insurance companies. However, it is important to understand that your health and accident insurance policy is an arrangement between you and your insurance company. You are personally responsible for all service charges incurred in our office. Until your insurance coverage has been verified, we expect payment in full when the services are rendered.

We ask that you keep our deductible charges current. After your deductible has been met, we request that you continue to keep your portion of your claim up to date. You are required to sign an "authorization and assignment of benefits" from and any other documents required by your insurance company on your first office visit. You are responsible for providing this office with insurance information and claim forms. You will be considered a cash-paying patient until this information is received. Our office does not guarantee that your insurance will pay. Regardless of what type of insurance you have, you are ultimately responsible for your account. Most insurance companies do not cover the cost of vitamin supplements and orthopedic supplies. Therefore, these costs are the responsibility of the patient. Payment must be made upon receipt of supplies.

_____ _____/_____/_____

Patient Signature Date

AUTHORIZATION TO RELEASE INFORMATION

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and hereby release you of any consequence thereof.

I understand that in the case of default on my part, that necessitates ***Comprehensive Health and Chiropractic Centre*** or its agents to employ legal and/or collection counsel, I am responsible for collection charges incurred. These charges will be added to my bill.

Should I be unable to meet the terms of this agreement at anytime, I agree to notify the office immediately.

_____ _____/_____/_____

Patient Signature Date

_____ _____/_____/_____

Staff Signature Date

CHCC AGREEMENT

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I agree to notify this doctor immediately whenever I have changes in my health condition(s) in the future.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable.

I understand that in the case of default on my part, that necessitates Comprehensive Health and Chiropractic Centre or its agents to employ legal and/or collections counsel, I am responsible for collection charges incurred. These charges will be added to my bill.

Should I be unable to meet the terms of this agreement at any time, I agree to notify the office immediately.

_____ _____/_____/_____

Patient Signature Date

_____ _____/_____/_____

Parent or Guardian Signature (if patient is minor) Date

CHCC Name: _____ Date: _____ Signature: _____