

3. Worker's Compensation Questionnaire

Worker's Comp. Ins. Name _____ Claim # _____
W.C. Ins. Address? _____
Phone () _____ Fax () _____ Adjusters' Name _____

Attorney Information:

Name _____ Phone () _____ Fax () _____
Address _____ City _____ State _____ Zip _____

Health Insurance Information:

Health Ins. Name _____ ID # _____
Group # _____ Insurance Phone # _____

1. Date of Injury _____ Location / Time of injury _____
2. Please, describe the injury _____

3. Have you seen any other doctors? () Yes, () No
If yes, name and phone # _____
4. Did you go to a hospital () Yes, () No
If yes, hospital's name? _____

5. What are your current complaints:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Elbow Pain | <input type="checkbox"/> Fever/Infection | <input type="checkbox"/> Jaw Pain |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> Ringing/Pain in ears | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Hand Pain | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Pins and Needles _____ |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Numbness _____ |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Urinary/Bowel difficulty | <input type="checkbox"/> Tingling _____ |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Thigh Pain | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Disc hernia/bulge |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fracture _____ |
| <input type="checkbox"/> Rib Pain | <input type="checkbox"/> Ankle Pain | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Foot Pain | <input type="checkbox"/> Constant Irritability | |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Loss of Balance | |
| <input type="checkbox"/> Forearm Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Memory | |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Signature of Patient or Parent/Guardian of Minor

Today's Date