QUINCE ORCHARD
MEDICAL CENTER

WORKER'S COMPENSATION QUESTIONNAIRE

Dear Patient: This information is considered confidential. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name ____ Date ____________

Please explain in detail how your accident happened ____________________________________

____

____

____

Give time and date present injury occurred ____________ □ AM □ PM ____________________ 20____

Where did you feel pain immediately after the accident? ____________________________________

Did you miss any time from work? □ Yes □ No How much time? ______________________________

Have you returned to work? □ Yes □ No If so, date returned to work ___________________________

Was any other doctor consulted after your accident? □ Yes □ No

If so, give doctor's name ___________________________________ □ 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 ____________

____

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 by accidents on the job? □ Yes □ No

Have you ever had a Worker's Compensation claim before? □ Yes □ No

Before the injury 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 this injury are your symptoms □ improving? □ getting worse? □ the same?

Name of your insurance adjuster ____

Have you hired an attorney? □ Yes □ No Litigation: □ Yes □ No □ Maybe

If so, name and address ____