WORKERS COMPENSATION QUESTIONNAIRE

Today's Date:_____

Please fill out the answers to the following questions to the best of your ability. If you have any difficulty with any questions or are unsure of how best to answer, please discuss those questions with the doctor before answering.

Last Name: _____ First Name: _____
Age: _____ Weight: _____ Height: _____
Are you: ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed ( ) Living with a significant other
Are you a parent? NO Yes, with 1 2 3 4 5 6 Children
Occupation: _____ For how long: ____ years, _____ months
Make and model of the vehicle you were in _____ Year _____
Date of Accident (___/____/_____) Which state did the accident take place in? _____

Please answer the following questions.

Where and how did the accident happen? _____
_____
_____
_____
Did you report the injury? **( ) NO or ( ) YES**
Have you had any other accidents or injuries since this accident? **NO or YES, If yes please explain.**
_____
_____
_____

Please complete one or more of the following statements.

Since the accident, my injury **prevents** me from _____
_____
Example: Since the accident, my injury prevents me from playing basketball, helping around the house and running. I did these things before the injury.

Since the accident, I have been **unable** to _____
_____
Example: Since the accident, I have been unable to go to school, make the beds, clean the house, drive the car or put on my o wn shoes.

Since the accident, I have had **difficulty** _____
_____
Example: Since the accident, I have had difficulty standing, sitting, working, sleeping, bending and lifting my child.

I have not been able to work ( ) since the accident, or ( ) since (___/___/_____)

( ) I have not seen a doctor for this injury until now. This appointment is my first since the accident.
( ) I have seen a doctor _____ Date: _____
Address _____
Phone #: ( ) _____-_____ **Dr. Initials:_____**