WORKERS' COMPENSATION QUESTIONNAIRE

In cases where injury is sustained at your workplace we must make sure we have all the information needed to convey an accurate story to your Workers Compensation Carrier. Please answer all questions in as much detail as possible.

Patient Name: _____ Date: _____

INSURANCE INFORMATION

Your employer's name: _____ Phone #: _____

Your employer's workers' comp. insurance: _____ Phone #:_____

Address: _____

Claim#: _____ Service Representative: _____

ACCIDENT INFORMATION

Please explain in detail how your accident happened:

_____

_____

_____

_____

_____

_____

_____

Time injury occurred: _____ Date of injury: _____

Was a witness present at the time of the incident: ◯ Yes ◯ No

Did you feel immediate pain after the accident: ◯ Yes ◯ No

If yes, where? _____

If not, when did you experience the pain? _____

Did you lose consciousness during the accident? ◯ Yes ◯ No If yes, how long? _____

Where did you go after the accident?

◯ Home ◯ Back to Work ◯ Hospital ◯ Private Doctor ◯ Chiropractor

Treatment received: _____

Did you report the accident to your supervisor? ◯ Yes ◯ No

When? _____ Name of supervisor: _____

Have you missed any work? ◯ Yes ◯ No When? _____

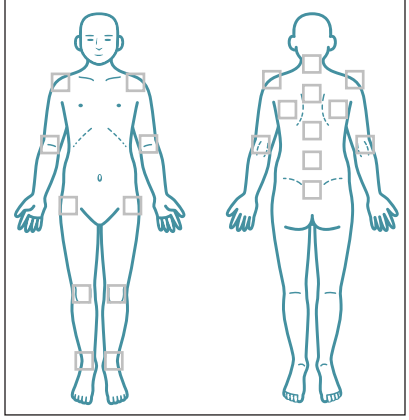
If yes, have you returned to work? ◯ Yes ◯ No If so, date returned to work: _____

Are your work activities restricted as a result of this accident? ◯ Yes ◯ No

If so, explain: _____

INFORMATION REGARDING YOUR INJURY

Please indicate where you are experiencing pain or discomfort.



ACKNOWLEDGEMENT & CONSENT

Patient Signature: _____ Date:_____

Dr. Kami Hansen | Dr. Caroline Ruppert | Heartland Family Chiropractic

2850 Cottage Grove Rd, Cottage Grove, WI | 608.839.3513

hfcinfo2009@gmail.com | www.HeartlandFamilyChiropractic.com

Struggle Survey

Tell us about your struggles, whether they be pain related (headaches, back pain, neck pain, wrist/ankle pain, etc.) or functional (digestion, energy, ADD/ADHD, vertigo, sleep, etc.) you have been experiencing.

If you are truly here for wellness and haven't had any struggles in the last month please check this box. ☐

Struggle 1: _____

Severity:(no issue) ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 (big issue) **Progression:** ◯same ◯better ◯worse

Impact on life: ◯mild ◯mod ◯severe **Frequency:** ◯< 25% ◯25-50% ◯50-75% ◯>75%

When did you notice the problem? _____ How did it start?_____

Better with: ☐rest ☐motion ☐ice ☐heat ☐meds ☐topicals ☐massage ☐chiropractic ☐other: _____

Worse with: ☐bending ☐movement ☐lifting ☐walking ☐sit ☐stand ☐lying ☐stress ☐other: _____

Feels like? ☐sharp ☐shooting ☐dull ☐ache ☐burning ☐stiff ☐stabbing ☐throbbing ☐numb ☐sore

Does it travel? (to arms, legs, etc.) ◯Yes ◯No If yes, where? _____

What time of day is it worst? ☐morning ☐afternoon ☐evening ☐falling asleep ☐while sleeping

What treatment(s) have you received? ☐PT ☐surgery ☐injection ☐chiropractic ☐acupuncture **Helpful?** ◯Yes ◯No

Struggle 2: _____

Severity:(no issue) ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 (big issue) **Progression:** ◯same ◯better ◯worse

Impact on life: ◯mild ◯mod ◯severe **Frequency:** ◯< 25% ◯25-50% ◯50-75% ◯>75%

When did you notice the problem? _____ How did it start?_____

Better with: ☐rest ☐motion ☐ice ☐heat ☐meds ☐topicals ☐massage ☐chiropractic ☐other: _____

Worse with: ☐bending ☐movement ☐lifting ☐walking ☐sit ☐stand ☐lying ☐stress ☐other: _____

Feels like? ☐sharp ☐shooting ☐dull ☐ache ☐burning ☐stiff ☐stabbing ☐throbbing ☐numb ☐sore

Does it travel? (to arms, legs, etc.) ◯Yes ◯No If yes, where? _____

What time of day is it worst? ☐morning ☐afternoon ☐evening ☐falling asleep ☐while sleeping

What treatment(s) have you received? ☐PT ☐surgery ☐injection ☐chiropractic ☐acupuncture **Helpful?** ◯Yes ◯No

Struggle 3: _____

Severity:(no issue) ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 (big issue) **Progression:** ◯same ◯better ◯worse

Impact on life: ◯mild ◯mod ◯severe **Frequency:** ◯< 25% ◯25-50% ◯50-75% ◯>75%

When did you notice the problem? _____ How did it start?_____

Better with: ☐rest ☐motion ☐ice ☐heat ☐meds ☐topicals ☐massage ☐chiropractic ☐other: _____

Worse with: ☐bending ☐movement ☐lifting ☐walking ☐sit ☐stand ☐lying ☐stress ☐other: _____

Feels like? ☐sharp ☐shooting ☐dull ☐ache ☐burning ☐stiff ☐stabbing ☐throbbing ☐numb ☐sore

Does it travel? (to arms, legs, etc.) ◯Yes ◯No If yes, where? _____

What time of day is it worst? ☐morning ☐afternoon ☐evening ☐falling asleep ☐while sleeping

What treatment(s) have you received? ☐PT ☐surgery ☐injection ☐chiropractic ☐acupuncture **Helpful?** ◯Yes ◯No

**For additional struggles, please fill out another "Struggle Survey" form to submit or write on the back of this page.

Contact Information Changes

If any of your contact information has changed please provide the new information below.

Address: _____

Phone Number: _____ E-mail Address: _____

Contact Preference: ◯Phone ◯E-mail ◯Text Form delivery: ◯E-mail ◯Mail ◯In person

Any changes to your insurance information? ◯Yes ◯No If yes, please supply us with your new insurance card.