Back In Action Chiropractic, Inc.

Dr. Eric Wruck, D.C.

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WORKER'S COMPENSATION QUESTIONNAIRE

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine what kind of care you will need. If we do not sincerely believe your condition will respond to chiropractic care, we will refer you for outside care accordingly. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you from Doctor and staff.

Date __________________________ Name ____

Sex _________ Marital Status _________ Date of Birth ______________ Home Phone ______________________________

Address _______________________________________ City _________________________ State ______ Zip ___________

Occupation ____ Who referred you to our office? __________________________

Social Sec. # _______-_____-__________ Bus. Phone (___)_____-________ Company Name ______________________

Spouses Name _______________________ Spouse's SS # _______-_____-__________ Employer ____________________

E-mail address:_____________________________ (to receive health information from our office)

Please explain in detail how your accident happened ____

____

____

____

Did you report this injury in writing at your work? ☐ *Yes* ☐ *No*

Have you retained an attorney? ☐ *Yes* ☐ *No* Litigation? ☐ *Yes* ☐ *No* ☐ *Maybe*

If so, name and address ____

Give time and date present injury occurred _____________________________ ☐ AM ☐ PM _________________ 20______

Where did you feel pain immediately after the accident? ____

Did you return to work? ☐ *Yes* ☐ *No* If so, date returned to work ____

Did you consult any other doctor? ☐ *Yes* ☐ *No*

If so, give the 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 ___________________________

____

Have you ever had a Workmen's Compensation claim before? ☐ *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?*

INJURIES INVOLVING LIFTING:

From what level were you lifting the object? ____

How many pounds was the object you were lifting? ____

What position were you in while you were lifting the object? ____

What type of pain did you feel immediately after the injury? ____

INJURIES INVOLVING FALLING:

Where at work did you fall? ____

What part of your body did you land on? ____

What other areas did you injure as a result of your fall? ____

OTHER TYPES OF ACCIDENTS:

____

____

JOB ANALYSIS:

What regular activities do you perform at your job? (such as bending, squatting, lifting, etc.) ________________________

____

How much do you regularly lift at your job? ____

Are you required to regularly bend while lifting at your job? ____

Please indicate the areas of pain with X's and areas of numbness or tingling with O's

HEALTH QUESTIONNAIRE:

Height: ______________________________

Weight: ______________________________

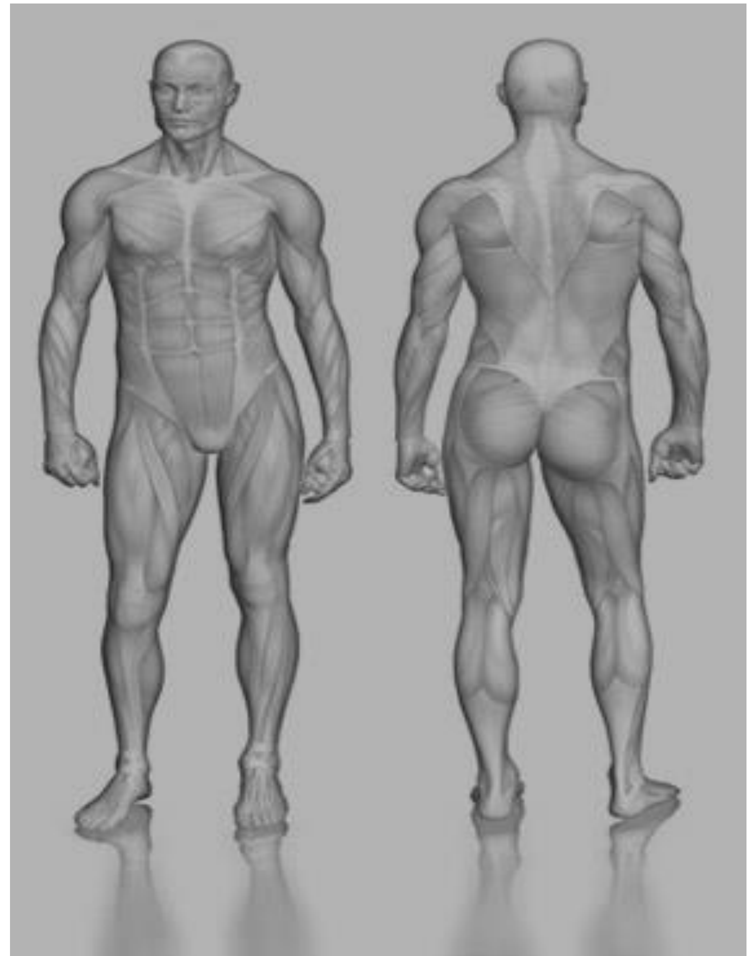
When was your blood pressure last taken?

____

What was your blood pressure?

____

Do you have a family history of High Blood Pressure? ☐ *YES* ☐ *NO*



Please indicate for by use of the following codes:
1-never had
2-previously had
3-presently have

MUSCULO-SKELETAL SYSTEM

____ Low back problems
____ Pain between shoulders
____ Neck problems
____ Arm problems
____ Leg problems
____ Swollen joints
____ Painful joints
____ Stiff joints
____ Sore muscles
____ Weak muscles
____ Walking problems
____ Ruptures
____ Broken Bones

GENITO-URINARY SYSTEM

____ Bladder trouble
____ Excessive urination
____ Scanty urination
____ Painful urination
____ Discolored urine

FEMALE

____ Vaginal discharge
____ Vaginal bleeding
____ Vaginal pain
____ Breast pain
____ Lumps in breast
Are you pregnant?
____ Yes ____ No

GASTRO-INTESTINAL SYSTEM

____ Poor appetite
____ Excessive hunger
____ Difficult chewing
____ Difficult swallowing
____ Excessive thirst
____ Nausea
____ Vomiting food
____ Vomiting blood
____ Abdominal pain
____ Diarrhea
____ Constipation
____ Black stool
____ Bloody stool
____ Hemorrhoids
____ Liver trouble
____ Gall bladder problems
____ Weight trouble

NERVOUS SYSTEM

____ Numbness
____ Loss of feeling
____ Paralysis
____ Dizziness
____ Fainting
____ Headaches
____ Muscle jerking
____ Convulsions
____ Forgetfulness
____ Depression

CARDIO-VASCULAR-RESPIRATORY SYSTEM

____ Chest pain
____ Pain over heart
____ Difficulty breathing
____ Persistent cough
____ Coughing phlegm
____ Rapid heartbeat
____ Blood pressure problems
____ Heart problems
____ Lung problems
____ Varicose veins

EYE, EAR, NOSE, AND THROAT

____ Eye strain
____ Eye inflammation
____ Vision problems
____ Ear pain or noises
____ Hearing loss
____ Ear discharge
____ Nose pain
____ Nose bleeding
____ Difficult breathing thru nose
____ Dental problems
____ Popping noise in jaw
____ Sore mouth
____ Sore throat
____ Difficulty swallowing
____ Difficult speech

INSURANCE INFORMATION

Name of person responsible for this account? ____

Relationship to patient____________________________________ Phone # ____________________

Address____ City_____________ State _______ Zip _______

Name of insured (employer or company name) ____

Address____ City _________________ State _____ Zip __________

Insurance Co.____ Phone # ___________________________________

Address____ City _________________ State _____ Zip __________

Date of Injury _________________________ Claim # _____________________

ADDITIONAL INSURANCE (Secondary Insurance)

☐ *Yes* ☐ *No* If Yes Complete the following:

Name of insured (employer)_______________________________ Relationship to Patient ______________________

Birth date_____________________ Insurance Co.______________________________ Phone # ________________

Group # _______________ Employer #_________________

Insurance Co. Address__________________________________ City_______________ State____ Zip __________

How much is your deductible?___________ How much have you used?__________ Max. annual benefit?__________