Dr. Brian S. Dixon,

CHIROPRACTIC CLINIC WEST

Ninety Berkshire Avenue
Springfield, Massachusetts 01109
(413) 739-7968

WORKER'S COMPENSATION QUESTIONNAIRE

This information is considered confidential. Please answer all questions completely and accurately so that we may properly understand your condition, and determine a chiropractic treatment plan.

Name:_____ Address:_____Apt#:_____
City:_____ State:_____ Zip:_____ Hm Phn#:_____ Cell Phn#:_____
Sex:_____ DOB:_____ Social Security#: _____Occupation: _____
Work Phn#: _____ Claim #:_____
Who referred you to our office:_____
Give the date and time that the present injury occurred:_____ ___AM ___PM
Where did you feel pain immediately after the accident:_____
_____
Please explain in detail how your accident happened:_____
_____
_____
Did you return to work: ____Yes __No if so, date of return to work:_____
Have you retained an attorney? ___Yes ___No If so, who?_____
Litigation? ___Yes ___No ___Maybe____
Did you consult any other health care provider regarding this accident? ___Yes __No
If so, give doctor's name:_____
Were there any X-rays or other diagnostic test taken after the accident? __Yes __No
If so, where were they taken?_____
Have you every injured this area before? ___Yes __No
If so when, and did you lose time from work at that time?_____
In your work do you have to favor any part of your body? __Yes _No
If so, explain:_____
Before this injury were you capable of working on an equal basis with others in your age group?
___Yes ___No If not, explain:_____
Are your work activities restricted as a result of this accident _Yes ___No
If so, explain:_____
Since this injury are your symptoms _____Improving ____Getting worse _____The same
Describe your pains and restrictions at this time:_____
_____
_____