CENTER FOR HEALTH
DR. GARY J. POST, CHIROPRACTIC PHYSICIAN
401-789-5008 401-789-5550 FAX

WORKERS COMPENSATION QUESTIONNAIRE

Name: ______________________________ Today's Date: ____________________________
Address: ____
Phone: Home:_____________Cell: _______________Work: ____________Email:____________________________
Social Security #: __________________Sex: ☐M ☐F Date of Birth:_____________Marital Status ____________
Occupation/Description______________________________________Your Employer:__________________________
Business Address:____
Contact Supervisor:____ Phone Number:______________________

Date and Time of Injury ____________________☐AM ☐PM Hours per day/week normally worked:___________

Was your accident directly related to your work? ☐Yes ☐No
Briefly describe the events that occurred just before and during your accident:_________________________________
____
____

Give the address where accident occurred if other than employers address: ___________________________________
____

Was anyone else present during your accident? ☐Yes ☐No
Did you report your accident to your employer? ☐Yes ☐No
What recommendations did your employer make just after your accident? ___________________________________
____

Has this type of accident happened to you before? ☐Yes ☐No
To the best of your knowledge, has this accident occurred in your workplace before? ☐Yes ☐No

Did the accident render you unconscious? ☐Yes ☐No If yes, for how long? _________________________________
Please describe how you felt immediately after the accident: ____
____

Have you gone to the hospital or been seen by any other doctor? ☐Yes ☐No
When did you go? ☐Just after the accident ☐The next day ☐Two or more days later
How did you get there? ☐Ambulance ☐Private transportation
Name of hospital and or attending doctor or chiropractor? ____
Describe any treatment you received: ____
How long were you treated? __________Are you improved ☐Yes ☐No _☐Unchanged ☐Getting worse
Were X-rays taken? ☐Yes ☐No Was medication prescribed? ☐Yes ☐No
Have you been able to work since the injury? ☐Yes ☐No If no, what dates?_________________________________
Are your work activities restricted as a result of this injury? ☐Yes ☐No
Is your condition worsening? ☐Yes ☐No ☐Unchanged ☐Comes and goes

Please list your chief complaints that are directly resultant from this injury:
1. ______________________________- **4.** ____________________
2. ______________________________ **5.** ____________________
3. ______________________________ **6.** ____________________

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful		Comfortable	Uncomfortable	Painful
Standing				Walking			
Sitting				Running			
Lying Down				Working			
Lovemaking				Lifting/Bending			

Please indicate your daily job duties and any activities you are occasionally asked to perform.

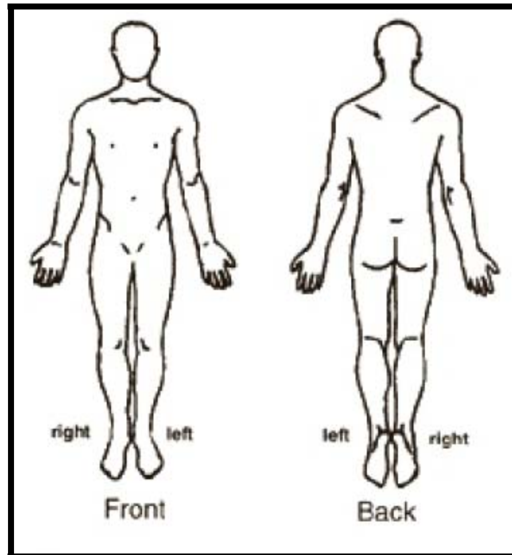
☐Standing ☐Driving ☐Operating Equipment ☐Bending ☐Stooping ☐Work with arms above head
☐Sitting ☐Twisting ☐Walking ☐Crawling ☐Typing ☐Lifting ☐Other____________________

What positions can you work in with minimum physical effort and for how long?______________________________
____ ☐N/A

Prior to the accident were you capable of working on an equal basis with others? ☐Yes ☐No ☐N/A
While in recovery is there any light duty work you can request? ☐Yes ☐No ☐N/A

Have you retained an attorney? ☐Yes ☐No If yes, whom? ____

Please mark on the pictogram with an X the site(s) where your pain is.



Overall Pain Scale

Please circle the number that best describes your pain. If multiple areas, please put numbers on the above chart.

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE

Please Sign: ______________________________ Date: ______________________