

Worker's Compensation Questionnaire

Full name: _____ Today's date: _____

Employer: _____ Employer phone: _____

Employer address: _____

Describe your work duties (give examples): _____

Lifting: 0 - 10 pounds 11 - 25 pounds 26 - 50 pounds 51 - 100 pounds 100+ pounds

How often are you required to lift the above weight? frequently occasionally never

Date of on-the-job injury: _____ Time of injury: _____ a.m. p.m.

Please explain in detail how the injury happened: _____

Did you feel pain immediately after the injury? Yes No If yes, where? _____

How about the next day(s)? _____

Did you continue working the day you were injured? Yes No

Have you missed any time from work as a result of this injury? Yes No If yes, how much? _____

Has your ability to work been altered due to this injury? Yes No

If yes, what can't you do now? _____

Did you consult a doctor for this injury? Yes No If yes, who? _____

What treatment did you receive? _____

Have your symptoms changed since the initial injury? Yes No If yes, how? _____

Have you ever injured this area before? Yes No If yes, when? _____

If injured before, did you lose time from work? Yes No

Have you ever had a Worker's Compensation claim before? Yes No When? _____

Have you retained an attorney for this injury? Yes No If yes, who? _____

Current Symptoms

List the present symptom(s) you are having: _____

Have you ever had a similar problem before? Yes No When? _____

Please explain in detail when and how your symptoms began: _____

What have you done to get relief? _____

Have you had previous treatment for this? Yes No
 If yes, when? _____ By whom? _____

What was done? _____

Current Pain Level

Please rate your pain severity on a scale of 0-10, with 0 being pain-free, and 10 the worst pain you have ever experienced.

How is your pain right now?

0	1	2	3	4	5	6	7	8	9	10
NONE	MILD Noticeable Pain, Minimal loss of motion.			MODERATE Moderate Pain that may cause Some degree of disability. Significant loss of motion.				SEVERE Severe Pain, Marked or total loss of motion.		

How high and low does your pain go? (circle 2 numbers)

0	1	2	3	4	5	6	7	8	9	10
NONE	MILD Noticeable Pain, Minimal loss of motion.			MODERATE Moderate Pain that may cause Some degree of disability. Significant loss of motion.				SEVERE Severe Pain, Marked or total loss of motion.		

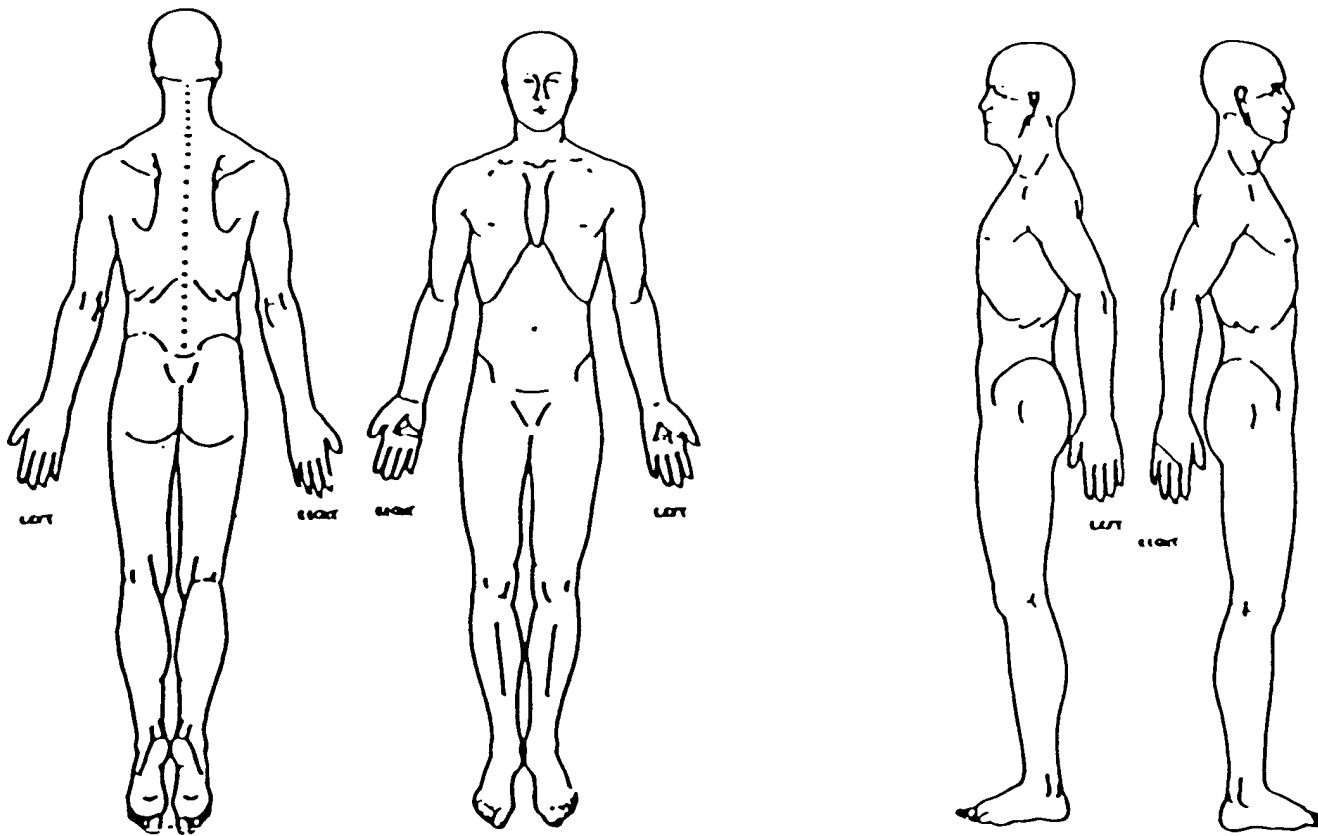
What makes your condition worse? Lifting Standing from seated position Nothing
 Walking Sitting Inactivity
 Exercise Standing Movement
 Home activities Work activities Other_____

What makes your condition better? Standing Exercise Physical Therapy
 Sitting Movement Pain Medication
 Sleep Walking Anti-inflammatories
 Lying down Inactivity Massage
 Stretching Hot shower/bath Nothing Other_____

Please mark your areas of pain on the figures below.

Shade and code area(s) of complaint: use codes: P = pain; N = numb; S = spasm

If these symptoms are spreading to other areas, please use arrows to show where and in what direction.



Check symptoms associated with your current problem:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Neck pain/stiffness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Numb feet/toes | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Mid-back pain | <input type="checkbox"/> Ringing in ear | <input type="checkbox"/> Numb hands/fingers | <input type="checkbox"/> Eyes sensitive to light |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Loss of concentration | <input type="checkbox"/> Unexplained weight change |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Pain behind eyes | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Digestive disorders | |

Do you have, or have you had, any of the following?

- | | | | |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Digestive disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Numbness | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer | |

Personal Information

Date of birth: _____ Social security number: _____ Driver's license #: _____

Home address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell Phone _____ Marital status: _____ Number of dependents: _____

Your occupation: _____ Employer: _____ Work phone #: _____

Work address: _____ City: _____ State: _____ Zip: _____

Spouse, parent, or guardian's name: _____ Relationship: _____

Their address: _____ Their phone #: _____

Who referred you to our office? _____

Past History

Have you had any past significant injuries? (list with approximate year) _____

Have you been involved in any past motor vehicle accidents? Yes No When? _____

If yes, were you injured? Yes No If yes, please describe: _____

What significant illnesses have you had? _____

Have you had any surgeries? (list with approximate year) _____

What medications are you currently using? _____

Mark any family illnesses: diabetes stroke cancer heart disease list all others _____

Do you have a primary care physician? Yes No If yes, who? _____

Have you received previous chiropractic care? Yes No If yes, by whom? _____

For what condition? _____

Is there anything else that you think the doctor should know? _____

Billing Information

It is important that we have complete and correct billing information so that we can expedite your claim

ON THE JOB

Date of injury? _____ Claim # _____ Filed 801 with your employer? Yes No
Filed 827? Yes No Is your claim open? Yes No Accepted Denied Unknown
Employer at time of injury? _____ Supervisor _____
Workers Comp. Insurance _____ Phone _____
Address _____ City _____ State _____ Zip _____
Are you enrolled in a Managed Care Organization? Yes No
Claim Examiner/Case Manager (if known) _____

PRIMARY HEALTH INSURANCE

Referral# _____ Co-Pay\$ _____ Effective Date _____ To _____
Insured Name _____ Date of birth _____ SSN/ID# _____
Insurance Carrier _____ Insurance phone _____
Group# _____ Employer _____
Insurance coverage for chiropractic? Yes No

SECONDARY HEALTH INSURANCE

Insured's Name _____ Date of Birth _____ SSN/ID# _____
Insurance Carrier _____ Relationship to patient _____
Insurance phone _____ Employer _____ Group# _____

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT I HAVE READ THE ABOVE AND AGREE TO ABIDE BY SAME.

Patient signature: _____ Date: _____

NOTICE TO PATIENT OF WORKERS' COMPENSATION BILLING PRACTICE

ORS 656.245(1) entitles an injured worker to all reasonable and necessary medical services that the nature of the injury or the process of recovery requires. Therefore, all medical services provided for an on-the-job injury will first be submitted to the workers' compensation insurer in accordance with the Oregon Administrative Rules governing billing practices.

ORS 656.005(12) allows a doctor of chiropractic medicine to be the attending physician for a period of 60 days from the date of first visit or for 18 visits, whichever first occurs, including initial and aggravation claims. After the 60th day or 18th visit, continued treatment will only be reimbursed by the workers' compensation insurance company if a medical doctor prescribes continued chiropractic treatment and provides a treatment plan to the insurance company prior to the commencement of treatment. Should the workers' compensation insurance company accept the claim for benefits before the 18th visit or 60th day, and the insurance company requires the injured worker to participate in a Managed Care Organization, the injured worker would then be required to see a doctor on the insurance company's preferred doctor list for that Managed Care Organization.

If a bill that has been submitted to the insurance company on an accepted claim has not been paid within 45 days, or has been submitted and the insurance company has denied payment of the bill, the bill will be forwarded to the patient with an explanation of the insurer's action. The patient may then retain the services of an attorney, whose fees will be paid by the insurance company, which may then request a hearing. No further billings will be submitted to the patient pending the outcome of litigation brought about by the patient's attorney. However, the patient may decide not to request a hearing but will then be responsible for payment of the bill. If the result of the hearing is that the bill is not the responsibility of the workers' compensation insurance company, the bill will be submitted to the patient's health insurance provider to be paid in accordance with the limits, terms and conditions of that policy. If the patient has no health insurance, the bill(s) will be submitted to the patient as if no workers' compensation claim existed.

PATIENT ACKNOWLEDGEMENT

By signing this document, I acknowledge that the above information has been provided to me and applies to any treatment that is provided by this medical service provider. I further acknowledge that, based on the above, I may be responsible for the payment of the services provided by this provider.

Date

Patient