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## 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 your 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<br>Noticeable Pain,<br>Minimal loss of motion. | | | MODERATE<br>Moderate Pain that may cause<br>Some degree of disability. Significant<br>loss of motion. | | | | SEVERE<br>Severe Pain, Marked or<br>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<br>Noticeable Pain,<br>Minimal loss of motion. | | | MODERATE<br>Moderate Pain that may cause<br>Some degree of disability. Significant<br>loss of motion. | | | | SEVERE<br>Severe Pain, Marked or<br>total loss of motion. | | |

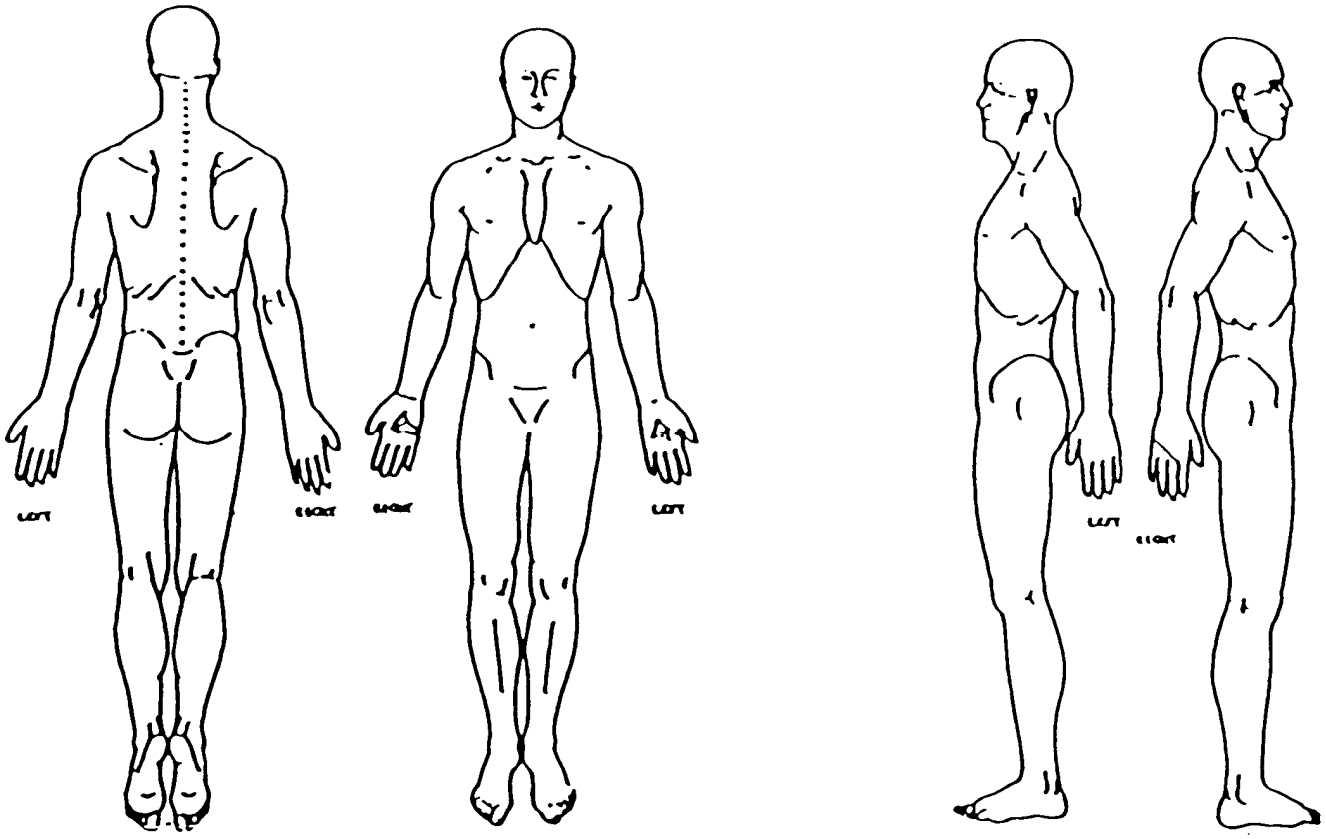
What makes your condition worse?

☐ 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:

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

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

| | | | |
|---|---|---|---|
| ☐ Dizziness | ☐ Asthma | ☐ Headaches | ☐ Digestive disorders |
| ☐ Anemia | ☐ Sinus trouble | ☐ Numbness | ☐ High blood pressure |
| ☐ Heart trouble | ☐ Heartburn | ☐ Tuberculosis | ☐ Loss of consciousness |
| ☐ Diabetes | ☐ Stroke | ☐ 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