Heartland Family CHIROPRACTIC LLC

Dr. Kami Hansen ~ Dr. Caroline Ruppert
2850 Cottage Grove Rd. Cottage Grove, WI 53527
Ph: 608-839-3513~Fax: 608-839-3533

WORKERS' COMPENSATION QUESTIONNAIRE

In cases where injury is sustained at your workplace we must make sure we have all the information needed to convey an accurate story to your Workers Compensation Carrier. Please answer all questions in as much detail as possible.

Patient Name:_____Date: _____

INSURANCE INFORMATION

Your employer's name: _____ Phone #:_____
Your employer's workers' comp. insurance co.: _____ Phone #:_____
Address: _____
Claim#:_____ Service Representative: _____

Your health insurance co. _____ Phone #:_____
Address: _____
ID#:_____ Group #:_____

If you have retained an attorney:
Name: _____ Phone#:_____
Address: _____

ACCIDENT INFORMATION

Please explain in detail how your accident happened: _____
_____
_____
_____

Give time and date present injury occurred: _____am/pm Date: ____/____/____
Was a witness present at the time of the incident: Yes No
Did you feel immediate pain after the accident: Yes No Where? _____
If not then when did you experience the pain? _____
Did you lose consciousness during the accident? Yes No If yes, how long?_____
Where did you go after the accident?
_____Home _____Back to Work _____Hospital _____Private Doctor
Did you report the accident to your supervisor? Yes No
When? _____ Name: _____
Has your employer acknowledged your accident? Yes No

Have you missed any work? Yes No When? _____

If yes, have you returned to work? Yes No If so, date returned to work: _____

Are your work activities restricted as a result of this accident? Yes No

If so, explain: _____

Before this injury, were you capable of working on an equal basis with others your age? Yes No

List any other comments relative to this accident: _____

_____

List any other complaints/health concerns not directly related to this accident: _____

_____

INFORMATION REGARDING YOUR INJURY

Have you tried any home remedies for your injury (aspirin, heating pad, ice pack, etc)?

_____

What aggravates your injury (i.e.; sitting, walking, bending, etc.)?

_____

What makes your injury better? _____

Since the injury, are your symptoms: Getting better/ Worse / About the Same

Have you seen any other health care providers for this injury? Yes No (If yes, complete this section)

Doctor's names and addresses: _____

_____

What examinations/treatments did your receive?

_____

_____

Doctor's diagnosis (if known): _____

Doctor's recommendations: _____

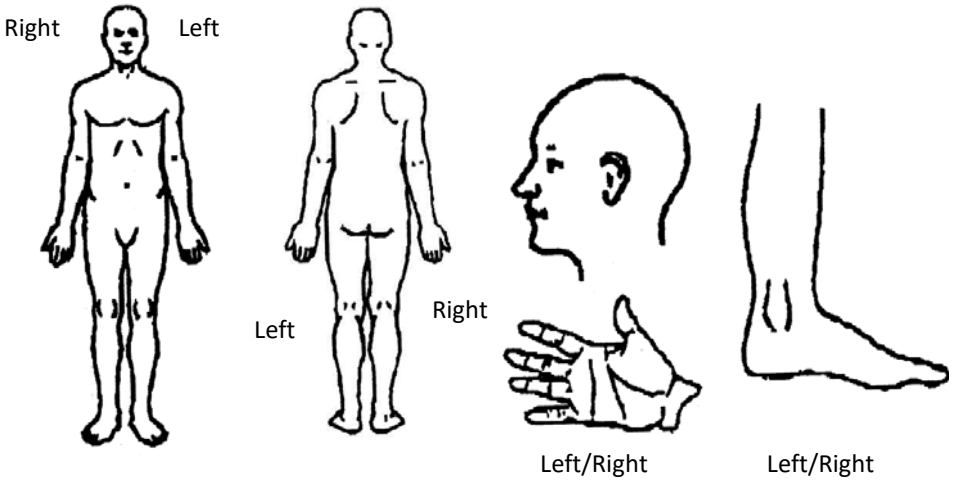
Currently being treated? Yes No

List any other comments relative to this injury:

_____

_____

INJURY DETAIL



N- Numbness	TH-Throbbing
P – Pain	SW-Swelling
SB-Stabbing	D – Dull
SH – Sharp	SO-Shooting
T – Tingling	B-Burning
A – Ache	C-Cramps
ST – Stiffness	S – Soreness
MS-Muscle Spasm	O-Other

Symptom Survey

List problems from most severe to least severe. Please be as specific as possible.

Problem #1._____
Location of pain:_____
Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe
Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%
When did you notice the problem? _____ What happened? _____
Better with (circle): rest ice heat stretching exercise pain relievers topical creams other_____
Worse with (circle): sitting standing walking bending twisting lifting movement other_____
Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore
Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? _____
What time of day is your problem the worse (circle): morning afternoon evening during sleep
What treatment have you received for this condition: medication physical therapy surgery chiropractic
other_____ Did it help? Y N

Problem #2._____
Location of pain:_____
Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe
Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%
When did you notice the problem? _____ What happened? _____
Better with (circle): rest ice heat stretching exercise pain relievers topical creams other_____
Worse with (circle): sitting standing walking bending twisting lifting movement other_____
Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore
Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? _____
What time of day is your problem the worse (circle): morning afternoon evening during sleep
What treatment have you received for this condition: medication physical therapy surgery chiropractic
other_____ Did it help? Y N

Problem #3._____
Location of pain:_____
Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe
Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%
When did you notice the problem? _____ What happened? _____
Better with (circle): rest ice heat stretching exercise pain relievers topical creams other_____
Worse with (circle): sitting standing walking bending twisting lifting movement other_____
Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore
Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? _____
What time of day is your problem the worse (circle): morning afternoon evening during sleep
What treatment have you received for this condition: medication physical therapy surgery chiropractic
other_____ Did it help? Y N

I attest that the above given information is complete and accurate to the best of my knowledge.
Signature:_____ Date:_____