WORKERS COMPENSATION QUESTIONAIRE File_____ Date _____

Please answer all questions completely so we can help you heal & accurately process your claim.

Name: _____ Nickname _____

Address_____ Apt# _____

City _____State_____Zip_____

Date of Birth _____ Age _____ Male Female

Cell Phone _____ Home Phone _____

Email_____ Work Phone_____

(Circle one) Single Married Partnered Divorced Widowed # of children_____

Name of spouse / partner _____

How did you hear about our office? _____

Emergency contact _____ Phone_____

Occupation when injured _____ Date &Time of injury _____

Employer's Name _____ Employer's phone #_____

Employer's Address _____

City _____State_____Zip_____

Employer's Insurance Co._____

Claim # _____ Policy # _____

Describe **How** and **Where** accident or cause of disability occurred *(include location and/or department)*

_____

_____

_____

Did you report the injury to your employer? Yes No

List the extent of your injuries as you know them _____

_____

Did you continue to work after the accident Yes No

Have you lost any time from work? Yes No If so, how long? _____

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

Since your injury, are your symptoms? ____ Improving _____ Getting worse _____ Same

Did you see anyone for this condition? Yes No

If so, who did you see & specialty?_____

Address_____ Phone _____

What treatment did you receive? _____

Have you been contacted by an insurance adjuster or company rep regarding this claim? Yes No

Name of your adjuster or rep _____

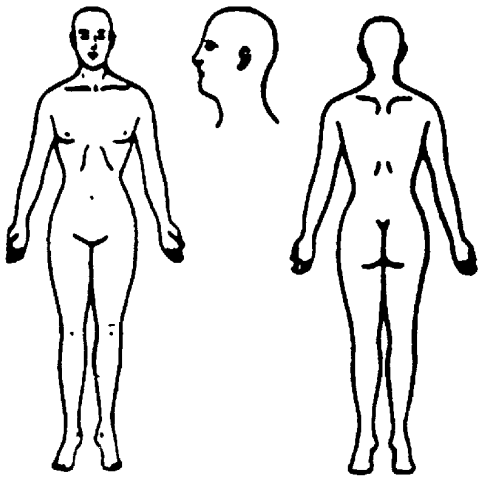
Have you retained an attorney or do you plan to retain an attorney? Yes No

If so, attorney's name and number _____

Casalino Chiropractic 1000 E. Camelback Rd. 85014 602.279.7376

Write the letter(s) that match your pain, from the injury/accident, on the image below

T – Tight **D** – Dull **A** – Achy **B** – Burning **S** – Spasm
N – Numb **O** - Pins & Needles **X** - Stabbing



List All Pain Locations	Circle Pain Level 	How Often Pain Occurs
1	0 1 2 3 4 5 6 7 8 9 10	☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%
2	0 1 2 3 4 5 6 7 8 9 10	☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%
3	0 1 2 3 4 5 6 7 8 9 10	☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%
4	0 1 2 3 4 5 6 7 8 9 10	☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%
5	0 1 2 3 4 5 6 7 8 9 10	☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%
6	0 1 2 3 4 5 6 7 8 9 10	☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Have you felt any of the following symptoms Since the Injury/Accident?

___ *Headache*
___ *Dizziness*
___ *Loss of Concentration*
___ *Forgetfulness*
___ *Confusion*
___ *Nervousness*
___ *Blurred Vision*
___ *Depression*
___ *Difficulty Sleeping*
___ *Loss of Energy*
___ *Ringing / Buzz in Ears*
___ *Paralysis*
___ *Fainting*
___ *Palpitations*
___ *Convulsions*

Did you have any physical complaints BEFORE this Accident? Y N If so, please describe in detail

_____

_____

_____

LIST MEDICATIONS OR DRUGS YOU ARE TAKING **AND** FOR WHAT OR WHY?

□ I AM NOT TAKING ANY MEDICATION OR DRUGS AT THIS TIME

Check any of the following conditions that YOU have had

__ Heart Disease
__ High Blood Pressure
__ Stroke / Aneurysm
__ Diabetes
__ Kidney Disease
__ Lupus
__ Gout
__ Seizures
__ Polio
__ HIV / AIDS
__ Valley Fever

Dizzy or **L**ight **H**eaded when
__ Moving your neck,
__ Changing positions
__ or Laying down

__ Osteoarthritis
__ Degenerative Disc Disease
__ Disc Injuries
__ Herniated / Slipped Disc
__ Spinal Block Injections
__ Lumbar / low back
__ Neck
__ Scoliosis
__ Osteoporosis/Osteopenia
__ Rheumatoid Arthritis
__ Unexplained weight loss

Abdominal Waist Size
__ Over 35 inches (female)
__ Over 40 inches (male)

Broken Bones – Location & When
_____
_____
_____

Surgeries - Location & When
_____
_____
_____

History of Cancer - Type
_____
_____
_____

Other
_____
_____

FAMILY HEALTH HISTORY

Mother's Side	***Father's Side***
__ Cardio Vascular Disease	__ Cardio Vascular Disease
__ High Blood Pressure	__ High Blood Pressure
__ Diabetes	__ Diabetes
__ Arthritis	__ Arthritis
__ Autoimmune Disease	__ Autoimmune Disease
__ Kidney Disease	__ Kidney Disease
__ Cancer - type	__ Cancer - type

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Casalino Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Casalino Chiropractic will be credited to my account upon receipt. However, I clearly understand that all services rendered to me are charged directly to me and that I AM PERSONALLY responsible for payment. I also understand that if I suspend or terminate my care and treatment, ANY fees for professional services rendered to me will be immediately due and payable. I also understand and agree to give Casalino Chiropractic Office, P.C. the POWER OF ATTORNEY to sign any insurance check mailed to the doctor with my name on the check for any services rendered at Casalino Chiropractic Offices, P.C. I authorize payment of medical benefits to Casalino Chiropractic Office, P.C. for any and all services rendered. I also authorize the release of any information pertinent to my case to any insurance, adjuster, or attorney involved in this case. ***NAME OF PERSON RESPONSIBLE FOR PAYMENT_____PATIENT SIGNATURE_____ DATE _____ PARENT OR GUARDIAN SIGNATURE_____ DATE _____***

JOB DESCRIPTION:

The following pertains to your job or position and its details. In terms of an 8-hour workday, “occasionally” means 33%, “frequently” means 34% to 66%, and “continuously” means 67% to 100% of the day.

1. In a typical 8-hour workday, I: (Circle # of hours/activity)

Sit:	1	2	3	4	5	6	7	8 hours
Stand:	1	2	3	4	5	6	7	8 hours
Walk:	1	2	3	4	5	6	7	8 hours

2. On the job, I perform the following activities:

	Not at all	Occasionally	Frequently	Continuously
Bend/stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Reach above Shoulder level	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Balancing	( )	( )	( )	( )
Pushing/Pulling	( )	( )	( )	( )

3. On the job, I lift:

	Not at all	Occasionally	Frequently	Continuously
Up to 10 pounds	( )	( )	( )	( )
11 to 24 pounds	( )	( )	( )	( )
25 to 34 pounds	( )	( )	( )	( )
35 to 50 pounds	( )	( )	( )	( )
51 to 74 pounds	( )	( )	( )	( )
75 to 100 pounds	( )	( )	( )	( )

4. Do you have to bend over while doing any lifting? ( ) yes ( ) no

5. Are your feet used for repetitive movements, such as in operating foot controls? ( ) yes ( ) no

6. Do you use your hands for repetitive actions, such as:

	Simple Grasping		Firm Grasping		Fine Manipulating	
Right Hand	( ) yes	( ) no	( ) yes	( ) no	( ) yes	( ) no
Left Hand	( ) yes	( ) no	( ) yes	( ) no	( ) yes	( ) no

7. Are you required to work on unprotected heights? ( ) yes ( ) no
   Describe: _____

8. Are you required to be around moving machinery? ( ) yes ( ) no
   Describe: _____

9. Are you exposed to marked changes in temperature and humidity? ( ) yes ( ) no
   Describe: _____

10. Are you required to drive motorized equipment? ( ) yes ( ) no
    Describe: _____

11. Are you exposed to dust, fumes and/or gases? ( ) yes ( ) no
    Describe: _____

12. Please list any additional comments: _____
_____
_____

Signature: _____ Date: _____