Thiele Chiropractic & Wellness File #: _____
Patient Name: _____ Date: ____/____/_____

WORK COMP QUESTIONNAIRE

Please answer all questions completely

This information will help us determine if chiropractic care can benefit you. If we do not believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and thorough as possible while completing this form. Thank you.

Name of Compensation Carrier: _____ Phone: _____

Address of Carrier: _____ City: _____ State: _____ Zip: _____

Employer Name: _____ Phone: _____

Employer Address: : _____ City: _____ State: _____ Zip: _____

Type of Business: _____ Your Occupation: _____

Date Injured: ____/____/_____ Approximate Time: _____ AM/PM

Did you have to take time off work due to the injury? ☐Yes ☐No

If Yes, date off work: ____/____/_____ to date returned (leave blank if still off): ____/____/_____

Accident Reported to employer? ☐Yes ☐No Name of person reported to: _____

Injured at: _____ City: _____ State: _____ Zip:_____

Type of work being done at the time of injury: _____

Please describe the injury: _____

_____

_____

Check symptoms you have noticed since the accident:

☐ Headache	☐Hand Pain	☐ Tension	☐ Light Sensitivity
☐ Dizziness	☐ Foot Pain	☐ Irritability	☐ Bowel Changes
☐ Neck Pain	☐ Buzzing/Ringing in Ears	☐ Nervousness/ Anxiety	☐ Sleep Problems
☐ Neck Stiffness	☐ Pins and Needles in Arms	☐ Depression	☐ Difficulty Concentrating
☐ Back Pain	☐ Pins and Needles in Legs	☐ Fatigue	☐ Shortness of Breath
☐ Rib Pain	☐ Numbness in Fingers	☐ Loss of Memory	☐ Stomach Pain
☐ Chest Pain	☐ Numbness in Toes	☐ Loss of Balance	☐ Cold Sweats
☐ Arm/Leg Pain	☐ Cold Hands	☐ Loss of Smell	☐ Face Flushed
☐ Shoulder Pain	☐ Cold Feet	☐ Loss of Taste	☐ Fainting

Symptoms other than above: _____

_____

_____

Did you have any similar symptoms or complaints before the accident? ☐Yes ☐No

If Yes, describe: _____

_____

Were you knocked unconscious? ☐Yes ☐No **If Yes**, for how long? _____

Where were you taken after the accident? _____

Hospitalized? ☐Yes ☐No **If Yes**, admitted? ☐Yes ☐No How Long? _____

Name of Hospital: _____

What was the diagnosis? _____

What treatment was given? _____

Was any other doctor consulted after your accident? ☐Yes ☐No

If Yes, Name and Specialty: _____

How long ago? _____

What was the diagnosis? _____

What treatment was given? _____

For how long? _____

Are you taking any medications? ☐Yes ☐No **If Yes**, please list: _____
_____

Do the medications help? ☐Yes ☐No ☐Unsure

Have you had Physical Therapy? ☐Yes ☐No **If Yes**, how often? _____

Has Physical Therapy helped? ☐Yes ☐No ☐Unsure

Since the injury, are your symptoms getting: ☐Worse ☐Improving ☐Staying the Same

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

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

JOB DESCRIPTION

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

In terms of an 8-hour work day, "**occasionally**" means 33%, "**frequently**" means 34-66%, and "**constantly**" means 67-100% of the day.

On the job I perform the following activities:

	NEVER	OCCASIONALLY	FREQUENTLY	CONSTANTLY
Bend/Stoop	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Pushing/Pulling	☐	☐	☐	☐
Reach Above Shoulder Level	☐	☐	☐	☐

On the job I lift:

	NEVER	OCCASIONALLY	FREQUENTLY	CONSTANTLY
Up to 25 pounds	☐	☐	☐	☐
26 – 50 pounds	☐	☐	☐	☐
51 – 75 pounds	☐	☐	☐	☐
76 – 100 pounds	☐	☐	☐	☐

Do you have to bend over while lifting? ☐Yes ☐No

Do you have assistance when needed for lifting heavy objects? ☐Yes ☐No

Are your feet used for repetitive movements, such as operating foot controls? ☐Yes ☐No

Do you use your hands for repetitive actions, such as: ☐Simple Grasping ☐Firm Grasping

☐Fine Manipulating ☐Using Vibrating Tools ☐Using High Impact Tools

Are there any other job related tasks that may cause a problem for your current condition/injury? ☐Yes ☐No

If Yes, please describe: _____

Any other additional comments? _____

_____

_____ _____/_____/_____ _____ _____/_____/_____
Patient Name (Printed) DOB Patient Signature Date

_____ _____/_____/_____
Doctor Signature Date