Lucas Chiropractic Clinic

Worker's Compensation Questionnaire

SECTION 1

1. Employee's Name (Last, First, Middle Initial)				2. Insurer Claim Number			3. Injury Date
4. Address				5. Sex ☐ Male ☐ Female			6. Social Security Number
City	State	Zip Code	Telephone				7. Birthdate
	AK						
8. Employer				9. Insurer			
10. Address				11. Address			
City	State	Zip Code	Telephone	City	State	Zip Code	Telephone
	AK				***AK***		

SECTION 2

12. Date Last Worked	13. Was Body Part Injured Before?				
	☐ No	☐ Yes	If yes, when and describe:		
14. Describe Injury and Tell How it Happened:					
15. Have You Seen any Other Doctor for this injury?				16. Hospitalized as inpatient? ☐ No	☐ Yes
☐ No ☐ Yes	If yes, list name and address:			Name of Hospital:	

Was your accident directly related to your work? Yes No

Briefly describe the events that occurred just before and during your accident: _____

_____

Did you report your accident to your employer? Yes No

Did the accident render you unconscious? Yes No If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

_____

_____

Describe any treatment you received: _____

_____

Were X-rays taken? Yes No

Was medication prescribed? Yes No If yes, what type? _____

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

Indicate the symptoms that are a result of this accident: _____

_____

_____

_____

Is your condition getting worse: Yes No

Signature: _____ **Date:** _____