ULTRA CHIROPRACTIC

Labor and Industries Questionnaire

Name: _____ Date: _____

Employer: _____ Business phone: (_____)_____

Work Address: _____

Occupation: _____

Give time and date present injury occurred_____ AM /PM_____ 20_____

Please explain in detail how your accident happened: _____

_____

_____

_____

_____

_____

Did you report this injury to employer?

☐No ☐Yes, I reported to: _____ Job title:_____

Do you have a claim open?

☐No ☐Yes, Claim number _____

Do you have an attorney?

☐No ☐Yes, name and address: _____

Did you return to work?

☐No ☐ Yes, date you returned to work: _____

Did you consult any other doctor?

☐No ☐Yes , doctor's name: _____

What treatments did you receive?

_____

Have you ever injured this area before?

☐No ☐ Yes, explain: _____

If injured before, did you lose time from work?

☐No ☐Yes

If you lost time from work with injuries prior to this injury, give the name of the doctor(s) consulted:

_____

Do any other diseases or accidents affect your employment?

☐No ☐Yes, explain: _____

Have you ever had a Workmen's Compensation claim before?

☐No ☐Yes

Before this injury were you capable of working on an equal basis with others your age?

☐No ☐Yes

Are your work activities restricted as a result of this accident?

☐No ☐Yes

Since this injury are your symptoms:

☐Improving ☐Getting worse ☐The same

Signature: _____ Date: _____