NeuroTarget Chiropractic

12358 River Ridge Blvd.
Burnsville, MN 55337
p(952) 681-7746
John Pietila DC, DACNB
Jennifer Engesether DC, DACNB

# Worker's Compensation Questionnaire

Please answer all questions completely or mark with N/A

Patient Name: _____Date: _____

Best contact number: _____Who referred you to our office? _____

Occupation: _____Company Name: _____

Company address: _____ City_____ St_____ Zip_____

## Workers' compensation insurance carrier:

Name: _____Phone: _____

Address: _____ City_____ St_____ Zip_____

Date of Injury: _____ Time of Injury: _____ AM_____ PM_____

Adjuster's name: _____ Contact number: _____

Claim number: _____

Please explain in DETAIL how your accident happened:

_____

_____

_____

Did you report the injury to your employer? _____Yes _____No

Where did you feel pain immediately after the accident? _____

Did you return to work? _____Yes _____No If so, date returned to work_____

Did you consult any other doctors? _____Yes ____No If so, give doctor(s) name _____

Have you ever injured this area before? _____Yes ____No If so, When? _____

If injured before, did you lose time from work? ____Yes ____No

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

_____

Do any other diseases or accidents currently affect your employment? ____Yes ____No

If so, explain_____

In your work, do you have to favor any part of your body? ____Yes ____No

If so, explain_____

NeuroTarget Chiropractic Name:_____DOB:_____

Have you ever has a workers' compensation claim before? ____Yes ____No

Before the injury, were you capable of working on an equal basis with others your age? ____Yes ____No

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

Since this injury, are your symptoms: ____Improving ____Getting worse ____The same

Have you retained an attorney? ____Yes ____ No

If so, name, address, and phone number:

_____

Present job title: _____

Present job involves:

_____Office work only _____Some light lifting ____Repetitive lifting _____lbs

Maximum lifting up to _____lbs _____Repetitive squatting _____Repetitive bending

____Repetitive stooping _____Repetitive kneeling _____hrs per day _____days per week

Other:

_____

_____

Patient signature: _____ Date: _____