Work/ Personal Injury Questionnaire

Date _____ **SS#**_____

Name_____ **Date of Birth**_____

Address_____**City**_____**State**_____**Zip**_____

Home Phone #_____ **Cell Phone #**_____

Are you currently a patient at Click Chiropractic? ☐ Yes ☐ No

Claim Number _____

Insurance Company _____

Address _____ **City**_____**State**_____**Zip**_____

Contact Name _____ **Contact Number** _____

Accident Date_____

How did the injury occur?_____

_____

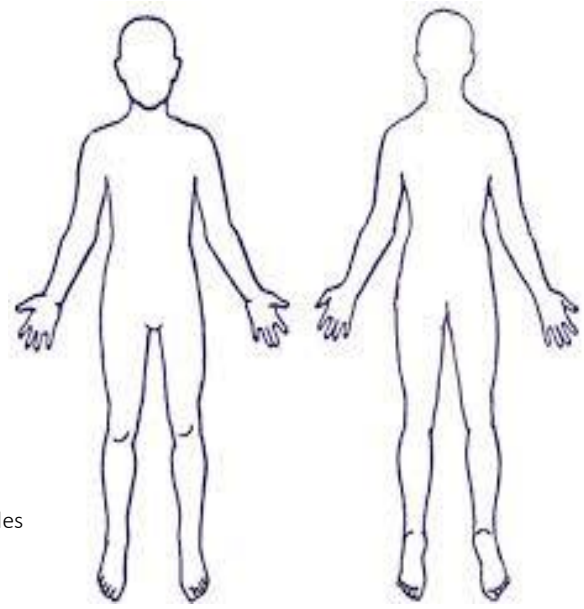
_____

List the extent of your injuries as you know them _____

_____

Put a number (1=low, 10=high) on the picture that represents pain level in the areas of complaint.
Use symptom key to mark your symptom (s) for the areas of complaint.
How often does this symptom occur?
Constant / Daily / Weekly / Rarely / Only Once
Does it interfere with any of the following activities?
Work / Sleep / Recreation / Daily Routine
Activities or movement that are difficult to perform?
Sitting / Standing / Walking / Bending / Lying Down

Symptom Key:
~~~ Dull Ache
/ / / Shooting
x x x Burning
*** Pins & Needles
000 Numbness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Describe any equipment/materials being used at time of injury / illness_____

_____

How did you feel immediately after the accident? Dizzy / Dazed / Disoriented / Unconscious / Nauseous / Nervous / Upset / Weak / In Pain

Did you go to the hospital? ☐ Yes ☐ No

Were you admitted? ☐ Yes ☐ No

When did you go to the hospital? At the time of the accident / Next day

How did you go to the hospital? Ambulance / Police car / Private Transportation

What treatment was given? None / Given pain medication/ Cervical collar / Physical therapy /

X-rayed / Stitched / Referred to family doctor / Surgery / Bandaged / Other _____

_____

Maximum weight you lift at your job?_____

What percentage of your work day is spent sitting?_____

Describe the setup of your work station (i.e. computer monitor level, chair, or desk) _____

_____

_____

Describe any repetitive movements you perform?_____

_____

_____

Click Chiropractic is a practice designed to keep individuals and families free from nerve interference caused by vertebral subluxations, to allow the body to more fully express its health potential. Chiropractic in this office consists of and is limited to 1. Analyzing the spine for the presence of vertebral subluxations; 2. Directing specific forces into the spine for the body to use in the correction of vertebral subluxation; 3. Educating and sharing the principles of chiropractic. Chiropractic is not a duplication of, substitution for, or alternative to medical care, does not include any diagnosis, treatment, cure, or prevention of any medical condition. I have read above, understand it completely and agree to become a practice member by these terms.

Signature _____ Date _____

Parent/ Guardian Signature _____ Date _____
(if patient is a minor)