Work Injury Questionnaire

Name: ____ Date __________________

360 Chiropractic Labor & Industries Office Policy: *As an injured worker, Labor & Industries will be paying for the charges provided that your claim is allowed. In order for us to be able to help you recover as quickly as possible, it is very important for you to follow the doctor's instructions. If your injuries have deemed you unable to work and you are placed on time-loss, you cannot miss any appointments. Labor & Industries considers time-loss workers free at all times to make all appointments. Whether you are placed on time-loss or not, if you miss three appointments and do not call to notify us that you will be missing those appointment your claim will be subject to closure. If you need to reschedule an appointment, please give us at least 24 hours notice.* ***Initial*** _______

I. Date & Time of Injury:

Date ____________ Time ___:____ am/pm

II. Description of Injury:

1. Describe in your own words what happened:

____
____
____
____
____
____
____
____
____

III. Immediately After Injury:

1. Did you lose consciousness?

☐ YES ☐ NO ☐ Don't Know

2. How did you feel?

☐ Confused ☐ Dazed ☐ Dizzy
☐ Nervous ☐ Weak
☐ Other_____________________________

3. If there were lacerations (cuts), where were they?

____
____
____

4. Where did you immediately develop pain?

Check all that apply to you and circle right side (R) or left side (L)

☐ Head ☐ Neck ☐ Pelvis
☐ Upper/Mid Back ☐ Abdomen
☐ Chest/Rib Cage ☐ Lower Back
☐ Shoulder R L ☐ Arms R L
☐ Elbows R L ☐ Wrists R L
☐ Forearms R L ☐ Hands R L
☐ Buttocks R L ☐ Hips R L
☐ Thighs R L ☐ Knees R L
☐ Legs R L ☐ Ankles R L
☐ Feet R L ☐ Other ________

5. Describe any other significant injury?

____
____

6. Emergency Care at Accident/Injury Site:

a. Did you receive emergency care?

☐ YES ☐ NO

b. What type of emergency care did you receive?

☐ Bandages ☐ Splint ☐ Brace
☐ Neck Collar ☐ Other________________

7. Destination after Accident/Injury:

a. Where did you go?

☐ Hospital ☐ Home ☐ Work
☐ School ☐ Other_________________

b. By whom were you driven?

☐ Myself ☐ Ambulance ☐ Friend
☐ Family Member ☐ Other ________________

IV. Hospital Visit after Injury:

1. When did you go: ______________________

2. Hospital name: ________________________

3. Examined by Dr.________________________

4. What was performed at the hospital?

____

5. What treatment was administered at the hospital?

☐ Oral Medication ☐ Topical Antiseptics
☐ Injections ☐ Bandages
☐ Sutures ☐ Ice Packs
☐ Hot Packs ☐ Splint
☐ Cast ☐ Brace
☐ Collar ☐ Support
☐ Surgery ☐ Other ____________

6. Instructions given when discharged from the hospital?

a. Were you told to see?

☐ General Practitioner ☐ Chiropractor
☐ Physical Therapist ☐ Orthopedist
☐ General Surgeon ☐ Neurologist
☐ Plastic Surgeon ☐ Internist
☐ Other _______________________________

b. What recommendations were made?

☐ No further care ☐ Observation
☐ No follow-up instructions
☐ Rest ☐ Ice ☐ Heat
☐ Collar ☐ Support
☐ Time off work ☐ Other ____________

7. Since your accident have you suffered from?

☐ Blurred Vision ☐ Chest Pain
☐ Nausea ☐ Palpitations
☐ Double Vision ☐ Difficulty breathing
☐ Vomiting ☐ Reduced Vision
☐ Constipation ☐ Impaired Hearing
☐ Inability to hold urine
☐ Frequent Urination
☐ Ringing in ears ☐ Painful Urination
☐ Anxiety ☐ Convulsions
☐ Restlessness ☐ Diarrhea
☐ Depression ☐ Dizziness
☐ Insomnia ☐ Headaches
☐ Mood swings ☐ Light Sensitivity
☐ Nervousness ☐ Reduced Appetite
☐ Fainting ☐ Loss of Balance
☐ Poor Memory ☐ Weakness
☐ Tension ☐ Fatigue
☐ Weight Gain ☐ Weight Loss
☐ Other ______________________________

8. Are you restricted in any areas as result of this accident?

☐ Daily Living ☐Occupational/Work
☐ Recreational Activities
☐ Other ______________________________

9. Have you missed work due to this accident?

☐ NO
☐NO, but limited work activity
☐ YES, From ___/___/___ to ___/___/___

10. Did you self treat your symptoms?

☐ Ice ☐ Heat ☐ Bed Rest
☐ Over-the-counter Medications ☐ Other____

11. Have you gotten medical treatment elsewhere?

☐ NO ☐ YES, explain _____________________

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____

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By Signing below, I hereby certify that the above information is complete and accurate to the best of my knowledge.

Patient Signature	Date