Nature's Way Chiropractic
Healing the Body the Natural Way

Dr. Sarah Ruther

Workers Compensation Questionnaire

Date of Injury: _____

Location: _____

Insurance Carrier: _____

Claim #: _____

Employer: _____

Name of Contact person & Phone Number: _____

_____

Please describe the injury and how it happened.

_____

_____

_____

_____

_____

_____

_____

Is this a work related injury? **Yes** **No**

Did you go to the Emergency Room? **Yes** **No**

If yes, in an ambulance? **Yes** **No**

Name of the Hospital Emergency Room: _____

_____

List any medications that you were given: _____

_____

_____

List any instructions that you were given: _____

_____

From the following list, circle the treatment(s) that you received at the Emergency Room:

Exam / X-Ray / MRI / CT Scan / Back Brace / Neck Brace / Home Instructions Other {please specify} ____ _____

Are you experiencing any of the following since the injury?

Fever/Weight loss ___Blurry vision ___Sore throat ___Headache ___Dizziness

Loss of balance ____ Nausea ___Breathing problems___Rapid heartbeat ___

Indigestion ___Anxiety/Irritability/Memory Lapses ___Urinary difficulties ___

Skin problems Fatigue ___ Allergic/Immunological disorders ___

Blood/Lymph disorders ___Hot/Cold flashes_____.

Were you off work as a result of your injuries? **Yes** **No**

If yes, from which dates {start & end}_____

What type of physical effort is required in your line of work?

_____ _____ _____

_____ _____ _____

Does your work aggravate your pain? **Yes** **No** **Somewhat**

Patient Information

I certify that the information I have provided on this form is true and correct to the best of my knowledge.

(Print Name) _____ _____

(Sign Name) _____ _____

Date: _____ _____