

# WORKER'S COMPENSATION QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Date \_\_\_\_\_  
Patient \_\_\_\_\_ No. \_\_\_\_\_

Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_

Type of work you do (labor) \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Social Sec. # \_\_\_\_\_ Business Phone \_\_\_\_\_ Company Name \_\_\_\_\_

Company Address \_\_\_\_\_

Please explain in detail how your injury occurred? \_\_\_\_\_

Give time and date present injury occurred \_\_\_\_\_  AM  PM \_\_\_\_/\_\_\_\_/\_\_\_\_

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 doctor?  Yes  No

Did employer send you to any other doctor?  Yes  No

If so, give doctor's name \_\_\_\_\_  D.C.,  M.D.,  D.O.,  D.D.S. \_\_\_\_\_

Doctor's Diagnosis \_\_\_\_\_

Did you lose time from work?  Yes  No

What medications are you presently taking? \_\_\_\_\_

Do any other diseases or accidents 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 \_\_\_\_\_

Have you ever had a Worker's 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 the injury, are your symptoms  Improving?  Getting worse?  The same?

Have you retained an attorney?  Yes  No Litigation?  Yes  No

If so, name, address & phone # \_\_\_\_\_

PLEASE DO NOT WRITE BELOW THIS LINE

This injury was verified by \_\_\_\_\_ on \_\_\_\_\_

Name of supervisor who verified the injury: \_\_\_\_\_

Time of call \_\_\_\_\_

# HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: \_\_\_\_\_

Patient: \_\_\_\_\_ No.: \_\_\_\_\_

## MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

## GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

### FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

ARE YOU PREGNANT?

YES  NO

## GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

## CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

## EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw Pain

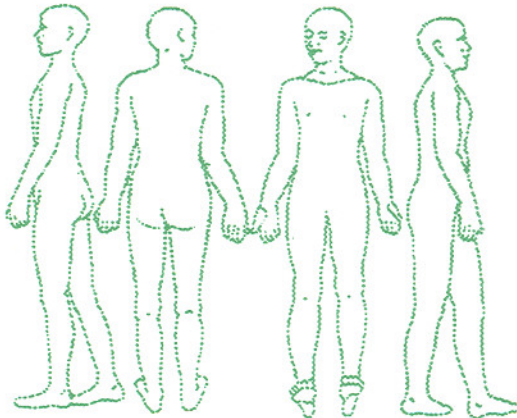
## NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

## HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Drug Abuse
- \_\_\_\_\_

## SYMPTOM LOCALIZATION



P \_\_\_ Pain                      T \_\_\_ Tender  
 N \_\_\_ Numb                     H \_\_\_ Hypoesthesia  
 S \_\_\_ Spasm

### Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature \_\_\_\_\_

..... DO NOT WRITE BELOW THIS LINE.....

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Patient Accepted?  Yes  No      Doctor's Signature \_\_\_\_\_

## Authorization for the Use or Disclosure of Protected Health Information

Bovadilla Chiropractic Clinic 6023 S. Sheridan Rd Tulsa Ok. 74145

Office (918) 493- 1493 Fax (918) 576-6789

**As required by the Health Insurance Portability and Accountability Act of 1996 Bovadilla Chiropractic Clinic may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.**

### AUTHORIZATION SECTION

I, \_\_\_\_\_ (print name) hereby authorize Dr Bovadilla the **use or disclosure** of the following health information that pertains to me.

ALL Medical Information  History and Physical  X-Ray Reports  X-Ray Images  
 Lab Reports  Operative Report  Discharge Summary  Consultation Reports  
 Other(explain) \_\_\_\_\_

for the following purpose<s>:  Continue Treatments  Request of patient or their legal representative  Other \_\_\_\_\_

I authorize the following persons or organization to the use or disclosures of my health information:  
\_\_\_\_\_

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Bovadilla Chiropractic Clinic 6023 S. Sheridan Rd Tulsa Ok. 74145. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire when information is release or obtained or one year after the date signed whichever comes first.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment and my eligibility for benefits will not depend in any way on whether I sign this authorization or not.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### REVOCACTION SECTION

I hereby revoke this authorization.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date