WORKER'S COMPENSATION QUESTIONNAIRE

Please answer all questions completed and return to office.
Employee's name & address:
Dhana a gundhan
Phone number:
Occupation: Sex: □ M □ F
Age: Sex: LI M LI F
Employer's name & address:
Phone number:
Type of business (retail, manufacturing, construction, etc.)
Workers Compensation Insurance Carrier:
On what date did your injury occur? What time? AM PM What address were you at when you were injured?
Did you notify your employer of this injury? ☐ Yes ☐ No Have you retained an attorney? ☐ Yes ☐ No If Yes, please give name & address:
Are you currently in litigation for this injury? ☐ Yes ☐ No ☐ Maybe Please explain how the injury or illness occurred:
What injuries did you suffer?
When was the last day you worked?
When did you return to work?
When was your first examination?
Who examined you?
Check one, if known: □ D.C. □ M.D. □ D.O. □ D.D.S. What was doctor's diagnosis?

(Please complete opposite side.)

Have you received any treatments prior to visiting this office? ☐ Yes ☐ No
What treatments did you receive?
Have you ever injured this area before? ☐ Yes ☐ No
If Yes, when did the injury occur?
Did you lose time from work? ☐ Yes ☐ No
If you lost time from work with injuries prior to this injury, please list doctor or doctors consulted:
Do you have other injuries or illnesses that affect your employment? ☐ Yes ☐ No
If Yes. please explain:
In your work, do you favor one part of your body more than others? ☐ Yes ☐ No If Yes. please explain:
Do you have a history of absenteeism caused from accidents on the job? ☐ Yes ☐ No
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 this injury are your symptoms: ☐ improving? ☐ getting worse? ☐ the same?