

Worker's Compensation/Injury Questionnaire

Please complete all of the following questions regarding your accident. These details are very important, and the doctor will use them with his examination and final care plan.

Claim Number _____

Full name _____ Today's date _____

Name of employer/company _____

Address _____

Phone number _____

Supervisor's name _____

When did the injury occur? Date _____ Time _____

Where did the injury occur? _____

Explain the accident in your own words _____

Did you inform your employer of the injury within 48 hours? Yes No If No, why? _____

1. **My accident was due to** (check ALL that apply): Slip Trip Stumble Fall Overtime
Not my regular job activity Other _____

2. **After the accident, when did your symptoms begin?** Immediately Couple of hours later
Half a day later The next day 2 days later Other _____

3. **How has your pain progressed since the accident?** Worse Same Improved

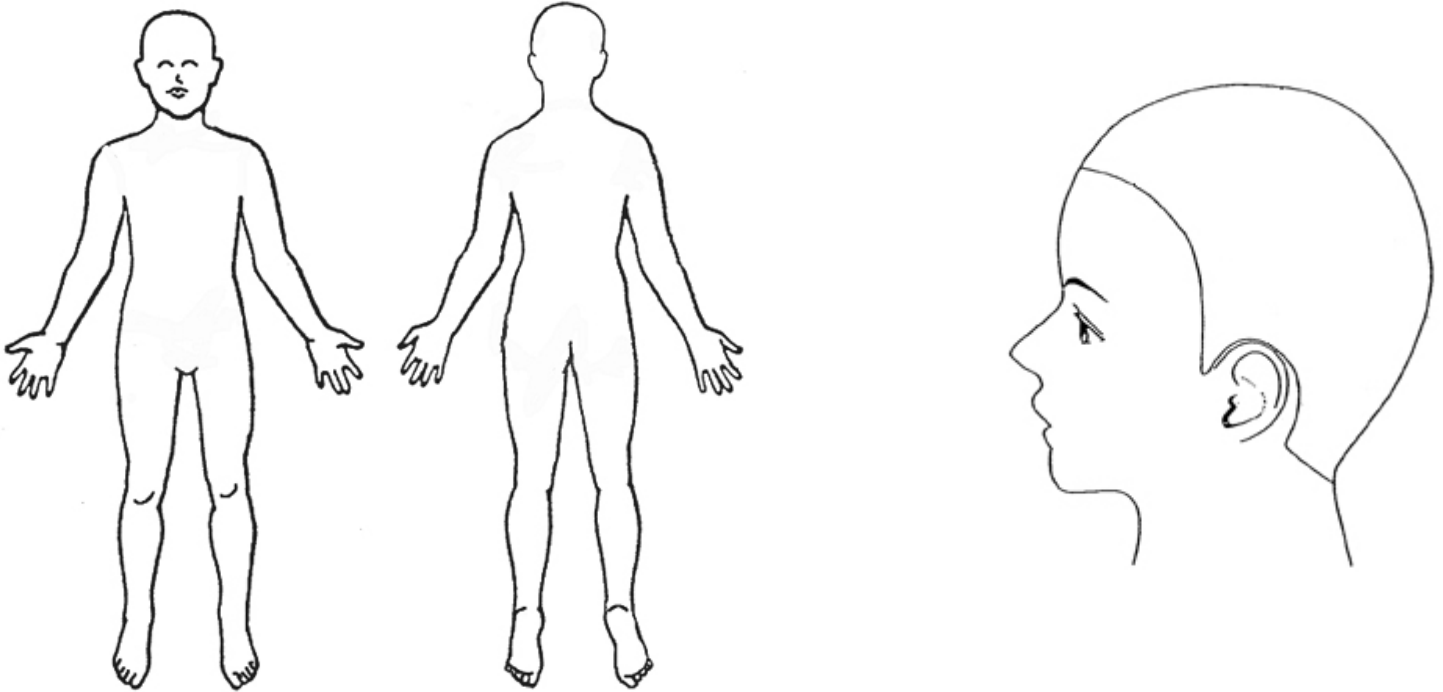
4. **List any work limitations since the injury** _____

5. **Do any other diseases or accidents affect your employment?** Yes No
If Yes, explain _____

6. **In your work, do you use any part of your body more than others?** (eg, repeatedly pulling a lever with your right hand) Yes No If Yes, explain _____

7. **List any limitations on your daily activities since the injury** (eg, pain with sitting, can't wash hair) _____

8. On the picture below, please mark an X over ANY area(s) that ARE or WERE painful



9. **Were you seen at a hospital?** Yes No If Yes, how many hours after the accident? _____
Hospital name _____
Were X-rays taken? Yes No _____
Medications prescribed at the hospital: Muscle relaxant Anti-inflammatory Painkiller
Other medication(s) _____
Time off from work given? Yes No If Yes, from _____ to _____

10. **Please list any other doctors/healthcare providers seen since the accident/injury**
A. Name _____ Address _____
Phone _____
Tests or treatment given _____
B. Name _____ Address _____
Phone _____
Tests or treatment given _____

11. **Previous accidents or significant injuries to areas injured in this accident**
A. Type of accident _____ Date _____
Area(s) injured _____
Did you recover completely? Yes No If No, explain _____
B. Type of accident _____ Date _____
Area(s) injured _____
Did you recover completely? Yes No If No, explain _____

Irrevocable Assignment of Benefits, Lien, & Authorization

I hereby authorize and direct you (my insurance company, liability insurance adjuster, and/or attorney) to pay directly to **Whole Chiropractic Healthcare, LLC/Dr. Thomas K. Hyland Robertson** ("office"), such as may be due and owing this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, worker's compensation benefits, or any insurance benefits obligated to reimburse me or from any settlement, judgment, or verdict on my behalf as may be necessary to adequately protect said office. I hereby further give a lien to said office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment, or verdict that may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

In the event my insurance company obligated to make payments to me upon the charges made by this office for services rendered refuses to make such payments, upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in the office's name. I further authorize this office to compromise, settle, or otherwise resolve said claim or cause of action as it sees fit.

I understand that I remain personally responsible for the total amounts due the office for services rendered. I further understand and agree that this Assignment, Lien, & Authorization does not constitute any consideration for the office to await payments; the office may demand payments from me immediately upon rendering services, at its option. Such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I agree to pay all costs of collection of any balance due this office, including reasonable attorney's fees.

I authorize the office to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien, & Authorization. I agree that the above-mentioned office be given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill. I, individually, and/or my successors hereby waive any statute of limitation, defense of the time for claims to be filed, any argument of estoppels, or other defenses to the timely filing of a claim by Whole Chiropractic Healthcare, LLC, as they pertain to any claim filed against me beyond any statutory period applicable to any proceeding after services were rendered. A photocopy of this agreement shall be considered as effective and valid as the original.

Date _____ Name _____

Signature _____

Witness signature _____

IF you have retained an attorney:

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect the above-named doctor/office.

Date _____ Name _____

Attorney Signature _____

Insurance Information

Name of **Responsible Party/Insurance Company**

Address City State Zip

Claim Number Policy Number Name of Insured