



# Franklin Back & Joint Care

Nicholas J. Julian, D.C.

Craig M. Julian, D.C.

38 Pond Street, #206

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296 Main Street

Franklin, MA 02038

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Milford, MA 01757

## WORKER'S COMPENSATION QUESTIONNAIRE

**Dear Patient, please fill out the questions below. PLEASE PRINT CLEARLY AND LEGIBLY:**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Marital Status: M S W D

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Hours Worked/Week \_\_\_\_\_

Employer City/State/Zip: \_\_\_\_\_

Contact Name at your job: \_\_\_\_\_

### Accident Information:

Date & Time accident occurred: **MONTH:** \_\_\_\_\_ **DAY:** \_\_\_\_\_ **YEAR:** \_\_\_\_\_ **TIME:** \_\_\_\_\_

Give all the details of how your accident occurred: \_\_\_\_\_

**CLAIM #:** \_\_\_\_\_

Adjuster's Name: \_\_\_\_\_ Adjuster Phone #: \_\_\_\_\_

Have you retained an attorney?..... **YES NO**

If an attorney is retained, give full name: \_\_\_\_\_

Address & Phone#: \_\_\_\_\_

Is there litigation?..... **YES NO**

After the accident, did you return to work?..... **YES NO**

Did you consult any other doctor?..... **YES NO**

Have you ever injured this same area before?..... **YES NO**

If injured before, did you lose work time?..... **YES NO**

Do any other diseases or accidents affect your work performance?..... **YES NO**

When working, do you have to favor any part of your body?..... **YES NO**

Do you have a history of absenteeism because of accidents on the job?..... **YES NO**

Have you had a worker's compensation claim before?..... **YES NO**

Before the injury, were you capable of working on an equal basis with your age?... **YES NO**

Are your work activities restricted as a result of this accident?..... **YES NO**

In what exact areas did you feel pain immediately after the injury? \_\_\_\_\_

If you returned to work, what was the date you returned? \_\_\_\_\_

**Treatment Information:**

If you consulted another doctor, give full name: \_\_\_\_\_

What was the doctor's diagnosis? \_\_\_\_\_

What treatment, if any, did you receive? \_\_\_\_\_

Were x-rays taken? \_\_\_\_\_

If you are limiting your body movement or favoring any body part, please explain: \_\_\_\_\_

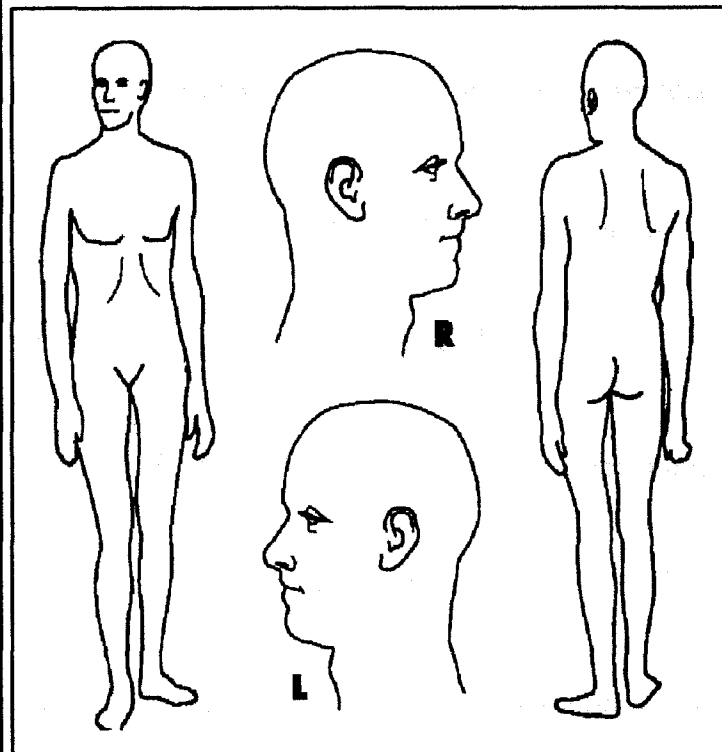
Since this injury, are your symptoms: (Circle One)      **SAME**      **BETTER**      **WORSE**

On a scale of 0-10 (10 being WORST), how do you feel overall today: \_\_\_\_\_

What makes the pain better (ex: heat, stretch, aspirin): \_\_\_\_\_

What makes the pain worse (ex: sitting, bending): \_\_\_\_\_

**Please mark areas of pain resulting from this accident on the figures below and answer the questions:**



**Please describe your pain (circle all that apply):**

- |       |          |          |
|-------|----------|----------|
| Sharp | Dull     | Throb    |
| Numb  | Tingling | Shooting |
| Stiff | Sore     | Achy     |

**Please circle anything that applies to this injury:**

- |                     |                   |
|---------------------|-------------------|
| abdominal pain      | chest pain        |
| difficult breathing | difficult walking |
| dizziness           | confusion         |
| headaches           | vision problems   |

**Please fill out the following health information:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Do you smoke:    YES    NO

Do you exercise: YES    NO

I, the patient, have completed this form - to the best of my knowledge and truthfulness - in regards to the personal injury I have sustained.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_