Chiropractic Central
1935 N.E. 39th Ave.
Portland, OR 97212

WORKMENS' COMPENSATION QUESTIONNAIRE

Name________________________ Birth Date___________ Phone #___________

Address_____________________ City____________ State_____ Zip _________

Your Occupation____

Employer_________________________________ Employer Phone #___________

Employer Address____
Street City State Zip

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1. Date of Accident____________________ Time of Day____________AM/PM

2. Are you off work now? _______ If yes, last date worked:__________

3. In your own words, please describe the accident:

4. What are your complaints or symptoms (since the accident):

5. Have you been treated by anyone else for this injury? _______
If yes, please give name and address of physician and type of treatment received below:

6. Were you hospitalized for this injury? _______ If yes, please give hospital name and dates of hospitalization below:

7. Did you have any physical complaints or impairments BEFORE THE ACCIDENT? ______ If yes, please describe in detail:

To the best of my knowledge the information provided above is true and correct.

____ _______________
Patient's Signature Date