Dr. James E. Hollingsworth
• Chiropractic Physician
• Diplomate American Academy of Pain Management
• Clinical Member American Psychotherapy and
Medical Hypnosis Association

Worker's Compensation Questionnaire

Please answer all questions completely

Name_____ Social Security #_____ Date_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ E-mail Address_____

Date of Birth _____ Age_____ Marital Status M S W D (circle one) Gender M F (circle one)

Occupation_____ Employer Name_____

Employer's Address_____ Employer Phone_____

Referred to our office by_____ Address_____

Please explain in detail how your injury occurred:_____

_____

_____

Date and time present injury occurred ___/___/_____ at _____ □ A.M. □ P.M.

You felt pain □ Immediately □ Later that day □ Next day □ Other _____

Where did you feel pain immediately after the accident?_____

Did you return to work? □ Yes □ No If so, date returned : ___/___/_____ Did you lose time from work? □ Yes □ No

Was any doctor consulted after the injury? □ Yes □ No If yes, did your employer send you to the Doctor? □ Yes □ No

Doctor's name _____ □ D.C. □ M.D. □ D.O. □ D.D.S

Doctor's diagnosis_____ Was treatment given? □ Yes □ No

Have you ever injured this area before? □ Yes □ No If yes, when?_____

Have you ever had complaints in the involved area before? □ Yes □ No

If so, what were the complaints? _____

What medications are you presently taking? _____

_____

Do any other diseases or accidents affect your employment? □ Yes □ No If yes, explain_____

_____

In your work, do you have to favor any part of your body? □ Yes □ No If yes, 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 accident, your symptoms are □ Improving □ Getting worse □ The same

Have you retained an attorney? □ Yes □ No □ Not Yet Litigation? □ Yes □ No

Attorney's name, address, and phone_____

----------DO NOT WRITE BELOW THIS LINE----------

The injury was verified by _____ on ___/___/_____

Name of supervisor who verified the injury: _____ Time of call: ____:_____ am pm

Please Complete Other Side