Atlee Chiropractic Center
Work Related Injury Questionaire

Name_______________________________________Sex: M / F
Social # ______________________________
Employer's Name_______________________Phone # ________________
Address_____________________________City, State, zip_____________
Date and time of accident____
Where did the accident happen___________________________________
Was anyone else present during the accident? YES / NO
Has this type of accident happened to you before? YES / NO
Was your accident directly related to work? YES / NO
Date and time your disability began?_______________________________
What date and time did you first leave work?________________________
Does employer know about this accident? YES / NO
Who did you report this accident to (Name and Title)__________________
Did you get permission to see a doctor? YES / NO Have you seen another Doctor for this condition? YES / NO If yes whom?_______________________When?___________________________
Was he/she a company doctor? YES / NO What was his/her diagnosis?
List any treatment he/she gave you________________________________
Do you have permission to change doctors? YES / NO
Will you file a claim under state or federal compensation acts? YES / NO
Do you have other insurance? YES / NO If yes, company name__________

Please explain in exact detail how this accident happened:____
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____

Please describe your symptoms in detail:____
____
____

Have you ever had similar trouble before? YES / NO If yes, please state complete details, including dates and names of doctors:____

Signature:____Date:______