Raschke Chiropractic Center, S.C.
Preventive Family Health Care
Fred W. Raschke, D.C.
PO Box 736
N1992 County Road F, Weyauwega, WI 54940

Workers' Compensation Questionnaire

Patient Information

Name: ____ Date: _________________
Address: ____
City/State/Zip: ____
Home Phone: _________________ Cell Phone ________________________
Employer: __________________________ Work Phone: _______________________
Occupation: _________________________ Social Security #: ____________________
Birth-date: _______________ Age: _____ Height: _______ Weight: ___________
Marital Status: _____ Spouse's Name: ____________ Children: Yes No How many? ________
Primary Care Physician: _______________________________Phone: _________________
Who referred you to our office? __ Ad __ Billboard __ Family/Friend Name ________________
__ Yellow Pages __ Another Doctor Name _____________
Email: _______________________________________
Preferred language: English ___ Other ___________________

Race: (circle) White Hispanic or Latino Race____________

Please answer the following questions relating to your work comp injury:

Are your work activities restricted as a result of this injury? ☐Yes ☐No
Was your accident directly related to your work? ☐Yes ☐No
Briefly describe the events that occurred just before and during your accident:___________________________
____
____

Can you name any witnesses to your injury?
____

Did you report your accident to your employer? ☐ Yes ☐No To whom was it reported?
____

Supervisors name ______________________________ Phone ___________________________________
Do you have health insurance?
____

Name of Carrier: ____ Phone ( )
____

Employer's Name : ____________________________________
______________________________________ Phone ( ) ______________ Address:
____
____

Date Injured: _______________________________ Hour _________________am / pm Are you off work: yes no

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Please describe how you felt immediately after the accident:____
____
____
____

Please list any doctors you have seen for this injury:______________________________________
____

Were x-rays taken? ☐Yes ☐No
Was medication prescribed? ☐Yes ☐No
If yes, what type:____
____
____

What treatment/therapy has been done for this problem?

___ Ice ___ Heat ________ _________ _________
___ Exercise ________ _________ _________
___ Massage ________ _________ _________
___ Electrical Stimulation ________ _________ _________
___ Injections ________ _________ _________
___ Chiropractic Adjustment ________ _________ _________

Indicate the symptoms that are a result of this accident:

☐Dizziness
☐Difficulty Sleeping
☐Arms /Shoulder Pain
☐Upper/Mid Back Pain
☐Memory Loss
☐Irritability
☐Numb Hands/Fingers
☐Lower Back Pain
☐Headache
☐Fatigue
☐Chest Pain
☐Back Stiffness
☐Blurred Vision
☐Tension
☐Shortness of Breath
☐Numb Feet/Toes
☐Ears Ringing/Buzzing
☐Neck Pain
☐Stomach Upset/Nausea
☐Stiff Neck
☐ Jaw Problems
☐Leg Pain
☐Other:

Is your condition getting worse? ☐Yes ☐No

Prior to this accident, have you ever had any physical complaints similar to what you have now?

Yes No Don’t know

If yes, please describe
____
____
____
____
____

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Have you returned to work since this accident? yes no

Are you required to drive automotive equipment? yes no

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on Back	☐	☐	☐
Lying on Side	☐	☐	☐
Lying on Stomach	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Sexual Activity	☐	☐	☐
Walking Short Distance	☐	☐	☐
Running	☐	☐	☐
Sports	☐	☐	☐
Bending Forward	☐	☐	☐
Operating Equipment	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐
Lifting	☐	☐	☐
Driving	☐	☐	☐
Twisting	☐	☐	☐
Crawling	☐	☐	☐
Working	☐	☐	☐
Lifting	☐	☐	☐
Typing	☐	☐	☐
Stooping	☐	☐	☐

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Past Medical History

Have you been diagnosed with any other medical problems? (Check all that apply)

___ High blood pressure
___ Diabetes
___ Cancer
___ Rheumatoid arthritis
___ Arthritis
___ Gout
___ Thyroid disease
___ Tension headaches
___ Migraine headaches
___ Stroke or TIA
___ Liver problems
___Sleep apnea
___ Brain aneurysm
___ Other ____________________
___ Seizures
___ Tuberculosis
___ Emphysema or asthma
___ Heart attack or angina
___ Irregular heart beat
___ Abnormal heart valve
___ Aortic aneurysm
___ Poor circulation
___ Ulcers in stomach or intestines
___ Kidney problems
___ Osteoporosis
___Insomnia
___Lyme's Disease
___Bowel problems
___Chronic Fatigue
___ Easy bleeding
___ Blood clots
___ Depression
___ Anxiety disorder
___ Mental illness
___ Addiction to alcohol / drug
___ HIV/AIDS
___ Major trauma (accidents, falls)
___ Broken bones
___ Severe head injury
___Digestive problems

Red flag check list for over 50

___Prolonged Corticosteroid use ___Unexplained weight loss ___Pain that does not improve with rest
___Progressive weakness in legs ___Urinary retention or incontinence ___Failure to respond to previous care
___None of these apply

Please list previous **surgeries** Reason Date Performed

____
____
____

Please list previous **accidents & hospitalizations**

____
____
____

Please list all **medications** that you presently take (prescription & non-prescription)

Medication	Strength	Frequency

Please list any nutritional supplements that you are presently take:

____
____
____

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Allergies: Yes or No

Medicine: ______________________ Severity: mild mod severe Reaction: _________________
Medicine: ______________________ Severity: mild mod severe Reaction: __________________
Medicine: ______________________ Severity: mild mod severe Reaction: __________________
Food: _________________________ Severity: mild mod severe Reaction: __________________
Environmental: __________________ Severity: mild mod severe Reaction: __________________

Personal / Social History

Please list your **hobbies**:
____
____

Do you **exercise** regularly? Yes No If so, what? _______________________________
Are you **pregnant**? Yes No
Do you use **tobacco**? Yes No
Smoking status: Current everyday # of years __ Former smoker # of Years since cessation__
Packs per day_____
Current someday never smoked
Packs per day_____

How many glasses of **water** do you drink per day? ____________________________________
Do you drink **caffeinated beverages**? Yes No ___ Cups/Cans of Coffee, Tea, Soda
Do you drink **alcoholic beverages**? Yes No Occasionally ___ # of drinks per day
Which of the following best describes your **stress level**? ___ Low ___ Moderate ___ Great
Do you feel that stress is affecting your health? Yes No

Do you **sleep** well? Yes No Number of hours per night ______
What type of **mattress** do you sleep on? ___ Firm ___ Soft ___ Waterbed Other __________
What type of **pillow** do you sleep with? ___ Feather ___Foam ___Fiberfill ___Orthopedic
What **position** do you sleep in? ___ Side ___ Back ___ Stomach
Do you wear **arch supports or orthotics**? Yes No If yes, what? __________________
Do you wear your **seatbelt** in the car? Yes No Sometimes

Family History

What diseases run in your family? Father(F) Mother(M) Brother(B) Sister(Si) Son(S) Daughter(D) Unknown(U)
_______ Diabetes ________ Cancer _______ Heart disease ________ Stroke
_______ Depression ________ Reaction to anesthesia ________ Arthritis______________ Rheumatoid Arthritis __________
High Blood Pressure_________ Other ______________________ Unknown_____________

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Education & Occupation Information

How many years of school did you complete? ____
What is your job title? ______________________ Are you: ( ) Full-time ( ) Part-time
How many hours per day do you work? ________ Days per week? _____________________
How long have you worked at your present job? _________Years _________Months
Does your job require you to frequently lift objects? Yes No
If yes, what is the heaviest load frequently lifted? ___________________
What is your primary work position? _______________________
Does work aggravate your present complaint? Yes No
Is there anything else you would like us to know about your health? Yes No
If yes, please explain____

____

I acknowledge that I have been given a copy of the *Notice of Privacy Practices* document on _________________ (date),
____________________________ (signature)

Thank you for completing this questionnaire. Guardian's signature is required if under 18 years of age. Signature implies consent to treatment.

_______________________________________ ______________
Signature Date

__________________________________ ____________
Doctor's Signature Date

Please note this form is to be used in conjunction with any forms required by your state's workers' compensation board. This form is not intended to be a substitute for any state or other authority's forms.

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