Back & Neck Clinic
OF NEW PRAGUE

Work Injury Questionnaire

Name: _____ Date: _____

Date of Birth: _____ Gender: Male or Female

Address: _____ City: _____ State: _____ Zip: _____

Cell # _____ Home # _____ Work # _____

Employer: _____ **Occupation**: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Date present injury occurred: _____ **Time** it occurred: _____ *AM* or *PM*

Where did injury take place: _____

1. Please explain in detail how your accident happened: _____

   _____

2. Was injury reported to your supervisor: ***Yes*** or ***No***

   - Name of person injury was reported to: _____ Title: _____

3. Phone number of contact person at your employment: # _____

4. Did company file a "First Report of Injury": ***Yes*** or ***No*** or ***Do Not Know***

5. Where did you feel pain immediately after the accident: _____

   _____

6. Did you have any of these symptoms prior to this injury: ***Yes*** or ***No***

   - If yes, what were the symptoms: _____

     - When did you have them: _____

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7. Did you have any other medical care for this injury: ***Yes*** or ***No***

- If yes, please give name of facility: _____
  - What treatments did you receive: _____

8. Did you miss any work because of this injury: ***Yes*** or ***No*** ♦ How much: _____

9. Have you retained an attorney: ***Yes*** or ***No*** Litigation: ***Yes*** or ***No*** or ***Maybe***

- Name of attorney: _____ Phone # _____

10. Private Insurance: _____ Policy# _____ Group # _____

11. Claim # _____

12. Adjuster Name: _____ Phone# _____

Signature: _____

(If patient is a minor we need guardian's signature)

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