Hessler Chiropractic
279 W Capac Road
Imlay City, MI 48444

P: (810) 724-0596
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Hesslerchiro.com

Hessler Chiropractic

Patient Questionnaire – Work-Accident

Patient Name: _____ Today's Date: ____/____/____

Date of Exam: ____/____/____ Provider: Dr. Joel Hessler New Patient □ Yes □ No

Basic Information about the Accident:

Date Accident Occurred or Started: ____/____/____

Time of Day when Accident Occurred or Started: ___:_____ AM / PM

Describe how the Accident took place:

_____

_____

_____

_____

Describe the condition or symptoms caused by the Accident:

_____

_____

_____

_____

Work-Accident Specific Information:

Check all that apply:

□ Did the accident occur on the premises of the facility where you normally work (i.e., your local work address)?
□ Did the accident occur during your normal working hours?
□ Did you report the accident to your Employer?
□ Is your Employer covered by Workers' Compensation Insurance under state law?
□ Has your Employer prepared an initial written report?
□ Does the Employer's Report describe the condition or symptoms you are experiencing?
□ Has a claim number been issued for this accident?
□ Have you received any written denial of liability from either your Employer or Worker's Insurance Comp Payer?

Additional Information Related to the Condition:

Describe your pain: □ Sharp □ Dull □ Stabbing □ Aching □ Radiating □ Burning □ Throbbing □ Numbness

What caused it?

_____

What aggravates it?

_____

What relieves it?

_____

_

Has the Patient ever had the same or similar condition or symptoms previous to this most recent occurrence? □ Yes □ No

When? ____/____/____

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Describe:
_____
_____
_____
_____

Please indicated any other healthcare providers who the Patient has seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
_____	_____	____/____/____
_____	_____	____/____/____

Have you missed work or school due to your injuries? □ Yes □ No
Do you smoke? □ Yes □ No Number of packs: _____
Do you drink alcohol? □ Yes □ No Number of Drinks _____

Notes:
_____
_____
_____
_____

Medical History:
Have you ever been in our office before? □ Yes □ No
List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1) _____ ____/____/____
2) _____ ____/____/____
3) _____ ____/____/____

Surgeries/Hospitalizations:
_____

Allergies (please list all):
_____

List all medications you are now taking and why: _____