

WORK INJURY QUESTIONNAIRE



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Your Name _____

What do you preferred to be called? _____

1. What is the date of the injury? _____

2. What time did the injury occur? _____

3. What is the name of your employer? _____

4. Please write your employer's address: _____

6. If you have an attorney, what is their name? _____

8. What are the City, State, and Zip of your attorney? _____

9. Please describe your incident in a few sentences: _____

10. Did you report the incident to your supervisor? _____

11. What is your Supervisor's name? _____

12. Did your employer send you to a doctor? If yes, please provide the doctor's name: _____

13. Did you go to a doctor on your own? If yes, please provide the doctor's name: _____

14. Are there any other problems that affect your employment? _____

15. Do you favor any part of your body at work due to this particular injury? _____

16. Before the injury, were you capable of performing equal work with others your age? Yes No

18. Have you injured this area before? Yes No

Thank you so much for taking the time to complete this form.
This form will help the doctor to better serve you with your health care needs.