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Workers' Compensation Questionnaire

Was your accident directly related to your work? Yes No

Briefly describe the events that occurred just before and during your accident: _____

Did you report your accident to your employer? Yes No

Did accident render you unconscious? Yes No

If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Describe any treatment you received: _____

Were x-rays taken? Yes No

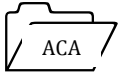
Was medication prescribed? Yes No

If yes, what type: _____

Are your work activities restricted as a result of this injury? Yes No

Indicate the symptoms that are a result of this accident:

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



Page 2

Is your condition getting worse? Yes No

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on Stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking Short Distance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Operating Equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Typing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.