Lake Shore Chiropractic Center
5449 Southwestern Blvd. Hamburg, NY 100 College Pkwy. Suite 100 Williamsville, NY
716-646-4000

WORKERS' COMPENSATION QUESTIONNAIRE

Name: _____ Date of Birth: _____
Employer's Name (At Time of Injury): _____
Employer's Address : _____
Street City State Zip
Employer's Phone(At Time of Injury) #: _____ Contact Person:_____

Job Title (On date of injury) _____
Work Duties(On date of injury)_____
WCB#: _____ INS. Claim#: _____
Work. Comp. Insurance Carrier: _____
Address: _____
Adjuster's Name _____Phone#: _____
Did You Report It? ___Yes ___No To Whom? _____
Date Of Accident: (Must Have Exact Date You Reported) _____
Where Did it Occur? City _____ County _____
Is Your Case Open? ____ Yes ____ No

In Your Own Words Describe Exactly How Your Injury Occurred _____
_____
_____

Have You Seen Any Other Doctor for Injury? ___Yes ___ No
Doctor's Name: _____
Diagnosis: _____
Treatment Rendered/Medication: _____
_____
Recommendations: _____
X-Rays? ____Yes ___No Where? _____

Did you have an IME (Independent Medical Exam) ____ Yes ____ No
Are You Working? ____ Yes ____ No
If No, When Did You Last Work? _____
If Yes, Are You Working Light/Limited Duty? _____Yes _____No
Do You Have a Permanent Disability Rating? _____Yes _____No
If Yes, For What Part of Your Body? _____

Patient Statement:
In the event I fail to prosecute for Workers' Compensation for this injury or condition or it is determined by the Workers' Compensation Board that the injury or condition is not a result of a compensable Workers' Compensation Case, I, _____
Hereby agree to pay _____DC his usual and customary fees for services rendered to the above named claimant in the above identified case.
Signature _____ Date: _____ 06/2016