



SPURLOCK SPINE CENTRE

WORKMAN'S COMP QUESTIONNAIRE

Today's Date: ___/___/___ Name: _____

1. Employer's business name (at the time of the accident): _____

2. Employer's phone #: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Describe your job: _____

3. How long were you with this company before this injury occurred? _____

4. Date of injury: ___/___/___ Date last worked: ___/___/___

5. What were you doing when you were injured; how did it happen? _____

6. If you are currently off work, what job specific duties are you unable to perform? _____

7. Do you have an attorney on this case? ___no ___yes

If yes, name: _____ Phone: _____

Address: _____ City: _____

State: _____ Zip: _____

8. First doctor seen (other than at Spurlock Spine Centre):

Name: _____ Date of 1st visit _____

Were x-rays taken? ___no ___yes If yes, what area? _____

Was a MRI ordered? ___no ___yes If yes, what area? _____

If yes, what facility performed the MRI? _____

What kind of treatment did you receive? _____

What benefits did you receive from the treatment? _____

Date of last visit? _____

9. Second doctor seen:

Name: _____ Date of 1st visit _____

Were x-rays taken? ___ no ___ yes If yes, what area ? _____

Was a MRI ordered? ___ no ___ yes If yes, what area ? _____

If yes, what facility performed the MRI ? _____

What kind of treatment did you receive? _____

What benefits did you receive from the treatment? _____

Date of last visit? _____

10. Third doctor seen:

Name: _____ Date of 1st visit _____

Were x-rays taken? ___ no ___ yes If yes, what area ? _____

Was a MRI ordered? ___ no ___ yes If yes, what area ? _____

If yes, what facility performed the MRI ? _____

What kind of treatment did you receive? _____

What benefits did you receive from the treatment? _____

Date of last visit? _____

11. Fourth doctor seen:

Name: _____ Date of 1st visit _____

Were x-rays taken? ___ no ___ yes If yes, what area ? _____

Was a MRI ordered? ___ no ___ yes If yes, what area ? _____

If yes, what facility performed the MRI ? _____

What kind of treatment did you receive? _____

What benefits did you receive from the treatment? _____

Date of last visit? _____