WHOLE CHIROPRACTIC HEALTHCARE

Worker's Compensation/Injury Questionnaire

Please complete all of the following questions regarding your accident. These details are very important, and the doctor will use them with his examination and final care plan.

Claim Number _____
Full name _____ Today's date _____
Name of employer/company _____
Address _____
_____
Phone number _____
Supervisor's name _____
When did the injury occur? Date _____ Time _____
Where did the injury occur? _____
Explain the accident in your own words _____
_____
_____
_____

Did you inform your employer of the injury within 48 hours? Yes ❑ No ❑ If No, why? _____
_____

1. **My accident was due to** (check ALL that apply): Slip ❑ Trip ❑ Stumble ❑ Fall ❑ Overtime ❑ Not my regular job activity ❑ Other _____

2. **After the accident, when did your symptoms begin?** Immediately ❑ Couple of hours later ❑ Half a day later ❑ The next day ❑ 2 days later ❑ Other _____

3. **How has your pain progressed since the accident?** Worse ❑ Same ❑ Improved ❑

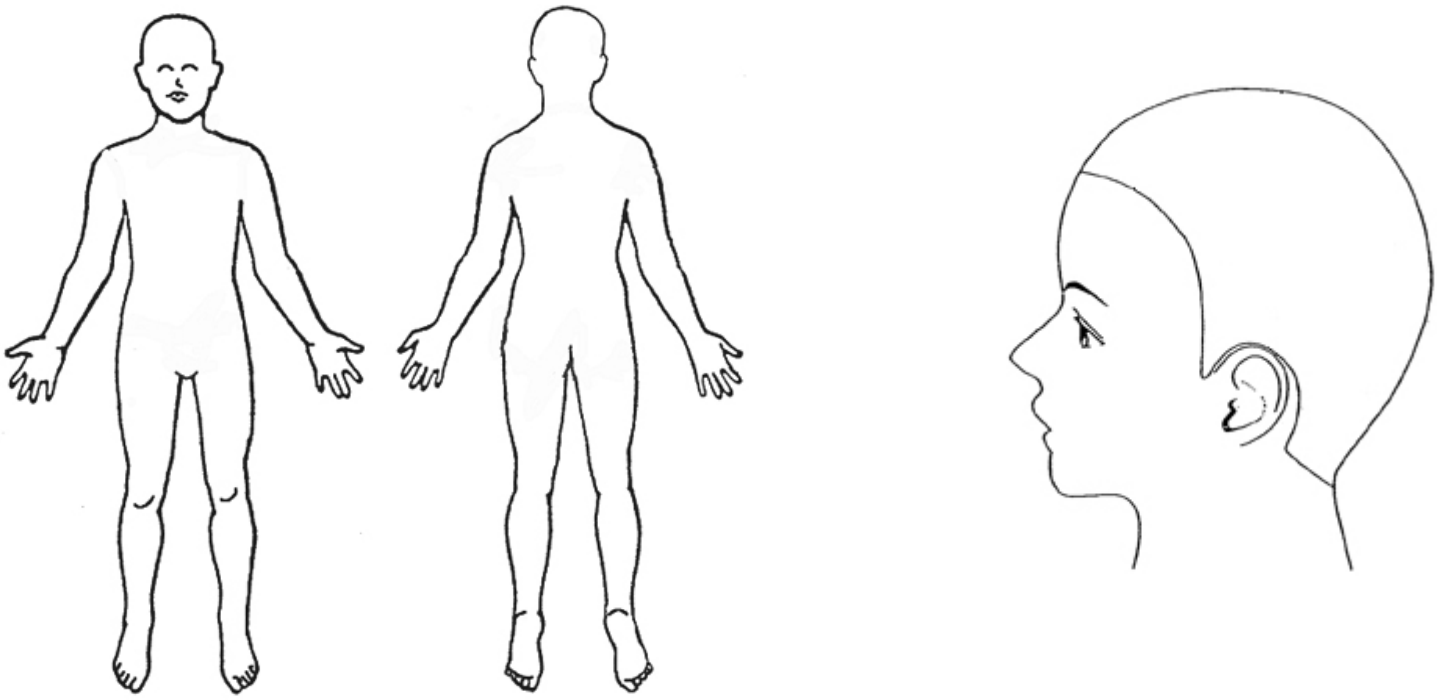
4. **List any work limitations since the injury** _____
_____

5. **Do any other diseases or accidents affect your employment?** Yes ❑ No ❑
If Yes, explain _____
_____

6. **In your work, do you use any part of your body more than others?** (eg, repeatedly pulling a lever with your right hand) Yes ❑ No ❑ If Yes, explain _____
_____

7. **List any limitations on your daily activities since the injury** (eg, pain with sitting, can't wash hair) _____

8. **On the picture below, please mark an X over ANY area(s) that ARE or WERE painful**



9. **Were you seen at a hospital?** Yes ❑ No ❑ If Yes, how many hours after the accident?_____
   Hospital name _____
   Were X-rays taken? Yes ❑ No ❑ _____
   Medications prescribed at the hospital: Muscle relaxant ❑ Anti-inflammatory ❑ Painkiller ❑
   Other medication(s) _____
   Time off from work given? Yes ❑ No ❑ If Yes, from _____ to _____

10. **Please list any other doctors/healthcare providers seen since the accident/injury**
   A. Name _____ Address _____
      Phone _____
      Tests or treatment given _____
      _____
   B. Name _____ Address _____
      Phone _____
      Tests or treatment given _____
      _____

11. **Previous accidents or significant injuries to areas injured in this accident**
   A. Type of accident _____ Date _____
      Area(s) injured _____
      Did you recover completely? Yes ❑ No ❑ If No, explain _____
      _____
   B. Type of accident _____ Date _____
      Area(s) injured _____
      Did you recover completely? Yes ❑ No ❑ If No, explain _____
      _____

C. Type of accident _____ Date _____
Area(s) injured _____
Did you recover completely? Yes ❑ No ❑ If No, explain _____
_____

12. **Have you ever filed a Worker's Compensation claim before?** Yes ❑ No ❑
If Yes, date(s) _____

13. **Were any of the areas injured in the present accident symptomatic before the accident?**
Yes ❑ No ❑ If Yes, explain _____
_____

I agree that all of the above information is correct and true to the best of my knowledge:

Print name Signature Date

(below for doctor's use)

WHOLE CHIROPRACTIC HEALTHCARE

Irrevocable Assignment of Benefits, Lien, & Authorization

I hereby authorize and direct you (my insurance company, liability insurance adjuster, and/or attorney) to pay directly to **Whole Chiropractic Healthcare, LLC/Dr. Thomas K. Hyland Robertson** ("office"), such as may be due and owing this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, worker's compensation benefits, or any insurance benefits obligated to reimburse me or from any settlement, judgment, or verdict on my behalf as may be necessary to adequately protect said office. I hereby further give a lien to said office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment, or verdict that may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

In the event my insurance company obligated to make payments to me upon the charges made by this office for services rendered refuses to make such payments, upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in the office's name. I further authorize this office to compromise, settle, or otherwise resolve said claim or cause of action as it sees fit.

I understand that I remain personally responsible for the total amounts due the office for services rendered. I further understand and agree that this Assignment, Lien, & Authorization does not constitute any consideration for the office to await payments; the office may demand payments from me immediately upon rendering services, at its option. Such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I agree to pay all costs of collection of any balance due this office, including reasonable attorney's fees.

I authorize the office to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Assignment, Lien, & Authorization. I agree that the above-mentioned office be given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill. I, individually, and/or my successors hereby waive any statute of limitation, defense of the time for claims to be filed, any argument of estoppels, or other defenses to the timely filing of a claim by Whole Chiropractic Healthcare, LLC, as they pertain to any claim filed against me beyond any statutory period applicable to any proceeding after services were rendered. A photocopy of this agreement shall be considered as effective and valid as the original.

Date _____ Name _____

Signature _____

Witness signature _____

IF you have retained an attorney:
The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect the above-named doctor/office.

Date _____ Name _____

Attorney Signature _____

Insurance Information

_____

Name of **Responsible Party/Insurance Company**

_____

Address City State Zip

_____

Claim Number Policy Number Name of Insured