FORM "A"

ARNE CHIROPRACTIC CLINICS, P.A.

WORK/COMP QUESTIONNAIRE

Name:_____ Date of Accident:_____

1. Name of employer at time of accident:_____
2. Length of time worked there prior to accident:_____
3. Type of work being done at time of injury:_____
4. In your own words, please describe accident:_____

_____

5. Have you been treated by another doctor for this accident? ( ) Yes ( ) No If yes, please list doctor's name and address:_____

   What type of treatment did you receive?_____

   How long were you treated by this doctor?_____
6. Are you: ( ) improved ( ) unchanged ( ) getting worse
7. What types of medicines are you taking?_____
8. Have you had physical therapy? ( ) Yes ( ) No If yes, how often?_____

   Does the physical therapy help? ( ) Yes ( ) No ( ) Don't know
9. Prior to the accident, have you ever had any of the physical complaints similar to what you have now? ( ) Yes ( ) No If yes, please describe:_____

   _____

   Were these similar complaints the result(s) of a previous accident(s)? ( ) Yes ( ) No

   Please provide details of previous accident(s):_____

   _____
10. Have you had any other serious accidents which required chiropractic or medical care? ( ) Yes ( ) No

    If yes, please describe:_____
11. Have you had any serious injuries or illnesses that required hospitalization? ( ) Yes ( ) No

    If yes, please describe:_____

    _____
12. Have you had any surgeries? ( ) Yes ( ) No If yes, please list type of surgery and date:

    _____

-Please complete reverse side-

13. Did you lose time from work due to this accident? ( ) Yes ( ) No If yes, list first date off work__

_____ Have you returned to work? ( ) Yes ( ) No If yes, list date returned_____

CURRENT COMPLAINTS

1. Currently, I have pain in my:	( ) low back	( ) mid back	( ) upper back	( ) neck
2. My pain began:	( ) gradually	( ) suddenly		
3. I have pain:	( ) sometimes	( ) all the time		
4. My pain goes into my:	( ) right leg	( ) left leg	( ) right arm	( ) left arm
5. I have tingling and/or numbness in my:	( ) right leg	( ) left leg	( ) right arm	( ) left arm
6. My pain is worse when I:				
cough or sneeze	( ) Yes	( ) No		
sit	( ) Yes	( ) No		
bend	( ) Yes	( ) No		
walk	( ) Yes	( ) No		
lift	( ) Yes	( ) No		
push	( ) Yes	( ) No		
pull	( ) Yes	( ) No		
7. My pain is worse with sexual activity:	( ) Yes	( ) No		
8. My pain wakes me up during the night:	( ) Yes	( ) No		
9. Changes in the weather affect my pain:	( ) Yes	( ) No		
10. I have neck stiffness:	( ) Yes	( ) No		
11. I have headaches:	( ) Yes	( ) No		
12. If I do get headaches, they occur:	( ) Daily	( ) 2 X Weekly	( ) 1 X Weekly	( ) Rarely

OTHER PAIN:

Please describe any current physical complaint which you are experiencing and were not previously on this questionnaire, or list any additional comments you wish to make regarding your condition:

JOB DESCRIPTION

1. In a typical 8-hour workday, I: (Circle # of hours/activity)

Sit:	1	2	3	4	5	6	7	8 hours
Stand:	1	2	3	4	5	6	7	8 hours
Walk:	1	2	3	4	5	6	7	8 hours

2. On the job, I perform the following activities:
(In terms of an 8-hour workday, "occasionally" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day).

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend/stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Reach above shoulder level	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Balancing	( )	( )	( )	( )
Pushing/Pulling	( )	( )	( )	( )
Lift more than 10 lbs	( )	( )	( )	( )
Lift more than 25 lbs	( )	( )	( )	( )
Lift more than 40 lbs	( )	( )	( )	( )

_____ _____

Signature Date