KENTUCKY PAIN INSTITUTE

WORKER'S COMPENSATION 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 Kentucky Pain Institute):

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? _____ **(If treated by more than one doctor, fill out second sheet)**

Name:_____ Today's Date:_____

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? _____