

Denver Integrated Spine Center
Workman's Compensation Questionnaire

7535 E. Hampden Ave., Suite 405 Denver, CO 80231

Date: _____

Name: _____ Birthdate ____/____/____

Address: _____ Phone Number: _____

1. Employer at time of accident _____
2. Employer's address _____
3. Date of accident _____
4. In your own words, please describe accident in as much detail as you can recall:

5. What part of your body did you injure?

6. Were you able to continue work following the accident? Yes No

7. What type of work was being done at the time of injury?

8. Were you capable of working on an equal basis with others your age and physical stature

prior to the accident? Yes No

9. Prior to this accident, have you ever had any physical complaints similar to what you now have? Yes No

Explain if answer is yes: _____

10. Dates you have been absent from work due to this injury:

Dates absent: _____

Date returned to work: _____

11. Have you been treated elsewhere for this accident? Yes No

If yes, by whom?

Address _____ Phone number _____

12. Have you reported your present injury to your supervisor or employer? **Yes** **No**

13. Name of that person _____ Title _____

Date reported _____ Time reported _____ **AM** **PM**

Please describe any current medical complaints which you are experiencing and were not previously covered on the health questionnaire or list any additional comments you wish to make regarding your condition.

Signature: _____ Date: _____

