



# Burland Chiropractic

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Chiropractic Physician

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## Workers Compensation Questionnaire

*If a Minor (under 18 years old), Name and Address of responsible parent/guardian:*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Status: Married Single Other \_\_\_\_\_

Referred to this office by: \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation/Title: \_\_\_\_\_

Employer address: \_\_\_\_\_

Employer phone: \_\_\_\_\_ Have you been able to work since the accident:  Yes  No

Workers Comp. Insurance Carrier: \_\_\_\_\_ Phone #: \_\_\_\_\_

Claims Adjuster: \_\_\_\_\_ Claim#: \_\_\_\_\_

Date of injury: \_\_\_\_\_

Do you have a primary care physician:  No  Yes, Who: \_\_\_\_\_

Have you been treated by another doctor since the accident:  No  Yes, Who: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_

Occupation at time of injury: \_\_\_\_\_

In a typical day, how many hours do you: Sit: \_\_\_\_\_ Stand: \_\_\_\_\_ Walk: \_\_\_\_\_

On the job, I perform the following activities: (Circle all that apply)

BEND /STOOP  
KNEEL  
SQUAT

CRAWL  
REACH ABOVE SHOULDERS  
CLIMB

MAINTAIN AWKWARD POSTURE  
LIFT  
PUSH/PULL

On the job, the heaviest I regularly lift is:

- 1-10 lbs     10-20 lbs     20-30 lbs     30-50 lbs     50-70 lbs     70+ lbs

Prior to this accident were you experiencing any similar physical complaints:  No  Yes, Explain: \_\_\_\_\_

\_\_\_\_\_

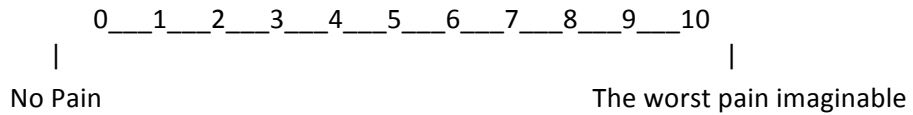
Please describe your accident/ injury: \_\_\_\_\_

\_\_\_\_\_

Current Complaints from injury: \_\_\_\_\_

\_\_\_\_\_

Please rate your level of discomfort at the moment:



Please use the diagram to describe your symptoms and mark the exact location:

