

# Chiropractor Questionnaire

**Claims Administrator:**  
Consociate • Dansig  
Attn: Underwriting  
111 E. Decatur Street, P.O. Box 1068  
Decatur, IL 62525  
Phone: (888) 242-4357  
Fax: (217) 451-9088

Group name: \_\_\_\_\_

Employee name: \_\_\_\_\_

Dependent name (if condition is for dependent) \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Symptoms experienced: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Due to an injury? \_\_\_\_\_

Any surgery done or expected? \_\_\_\_\_ When? \_\_\_\_\_

Type? \_\_\_\_\_

Any hospitalizations related? Yes or No

Length of stay/treatment: \_\_\_\_\_

How often do you typically visit the chiropractor? \_\_\_\_\_

Dates of last 3 visits: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Findings/treatment: \_\_\_\_\_

Recommendations for further treatment or procedures \_\_\_\_\_

\_\_\_\_\_

Please be advised that you may be required to submit medical records.

Employee signature: \_\_\_\_\_ Date: \_\_\_\_\_

