

WORKERS' COMPENSATION QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Name _____ Sex _____ Marital: M S W D Age _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Your Social Security No. _____ Work Phone _____ Home Phone _____

Who referred you to our office? _____

Name of employer at time of accident: _____ Phone (_____) _____

Employer's Address _____ City _____ State _____ Zip _____

Type of Business _____ Your Occupation _____

Date Injured _____ Hour _____ AM/PM Last Date Worked _____ Are you off work? Yes No

Accident reported to employer? Yes No Name of person reported accident to _____

Have you returned to work since this accident? Yes No If yes, Date _____

Light duty Regular duty Full time Part time

Length of time worked there prior to accident: _____

Type of work being done at time of injury: _____

In your own words, Please explain in detail how your accident happened _____

Where did you feel pain immediately after the accident? _____

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? _____

Since this injury are you improving? getting worse the same?

Are your work activities restricted as a result of this accident? Yes No

If yes, give a percentage of the restriction _____

Are your recreational activities restricted as a result of this accident? Yes No

If yes, give a percentage of the restriction _____

OVER

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

If yes, describe: _____

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

Please provide details of accident(s): _____

Have you ever injured this area before? Yes No If so, when? _____

If injured before, did you lose time from work? Yes No

If you lost time from work with injuries prior to this injury, give name of doctor or doctors consulted _____

Do any other diseases or accidents affect your employment? Yes No If so, explain _____

In your work do you have to favor any part of your body? Yes No If so, explain _____

Do you have a history of absenteeism caused from accidents on the job? Yes No

Have you ever had a Workers' Compensation claim before? Yes No

Before the injury were you capable of working on an equal basis with others your age? Yes No

What types of medicines are you taking? _____

Do these medicines help? Yes No Don't know

Have you had physical therapy? Yes No If yes, how often? Daily Every other day

Several times a week Weekly Every other week Monthly Other _____

Does the physical therapy help? Yes No Don't know

Have you had any other serious accidents which required medical care? Yes No

Describe: _____

Have you had any serious illnesses that required hospitalization? Yes No

Describe: _____

Have you had surgeries? Yes No If yes, list type of surgeries and dates: _____

Have you had any nervous or mental illness? Yes No If yes, describe: _____

Have you had psychiatric care? Yes No

Have you received a medical discharge from the Armed Forces? Yes No

CURRENT COMPLAINTS

- Currently, I have pain in my Low back mid back Upper back neck
- My pain began gradually suddenly
- I have pain sometimes all of the time
- My pain goes into my right leg left leg both right arm left arm both
- I have tingling and/or numbness in my right leg left leg both right arm left arm both
- My pain is worse when I cough or sneeze sit bend walk lift push pull
- My back is worse with sexual activity Yes No
- My pain wakes me up during the night Yes No
- Changes in the weather affect my pain Yes No
- I have neck stiffness Yes No
- I have headaches Yes No sometimes all of the time
- My pain is worse when I turn my head Yes No

OTHER PAIN: Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition:

JOB DESCRIPTION

Briefly explain your job description: _____

In an average 8 hour workday: (Circle No. of Hours)

- I Sit 1 2 3 4 5 6 7 8 Hours % _____ of the time 33% = Occasionally
- I Stand 1 2 3 4 5 6 7 8 Hours % _____ of the time 34-66% = Frequently
- I Walk 1 2 3 4 5 6 7 8 Hours % _____ of the time 67-100% = Continuously

On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend / Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing / Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

On the job, I lift:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Up to 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 to 24 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25 to 34 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35 to 50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 to 74 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75 to 100 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have to bend over while doing any lifting? Yes No

Are your feet used for repetitive movements, such as in operating foot controls? Yes No

Do you use your hand for repetitive actions such as:

	SIMPLE GRASPING	FIRM GRASPING	FINE MANIPULATING
Right hand	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Left hand	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you required to work on unprotected heights? Yes No

Describe: _____

Are you required to be around moving machinery? Yes No

Describe: _____

Are you exposed to marked changes in temperature and humidity? Yes No

Describe: _____

Are you required to drive automotive equipment? Yes No

Describe: _____

Are you exposed to dust, fumes and/or gases? Yes No

Describe: _____

Please list any additional comments _____

Signed: _____ Date: _____

SIGNATURE OF PATIENT