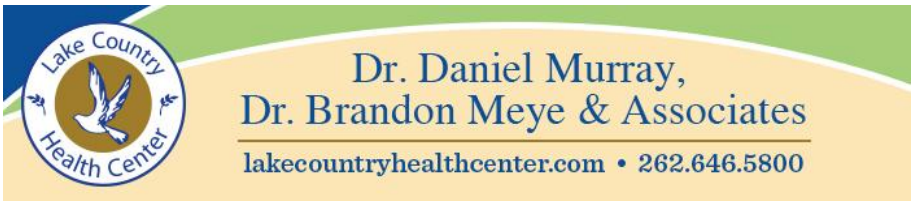

WORKER'S COMPENSATION INJURY QUESTIONNAIRE

(Please Print)

Name: _____ Today's Date: _____
Employee's Address:_____
DOB:_____ Email:_____ Phone:_____
How did you find our office? How were you referred?_____
Employer's Business Name at time of accident: _____
Employer's Phone: _____ Ext: _____ Employer's Address: _____
Your Occupation: _____ Length of time at this job: _____ Hours worked per day: _____
Date of injury: _____ Time of Injury: _____
If no specific date, when did you first begin to experience problems? _____
Please explain what you were doing at the time you were injured and how the accident happened (lifting, bending, walking, carrying, standing, driving, etc.): _____
_____
Did you finish what you were doing? □Yes □No When did the pain begin? _____
Where did you first feel pain? _____ Was the pain intense at first or did it gradually worsen? _____

REPORTED ACCIDENT/ACCIDENT OBSERVER

On what date did you report this injury? _____
Who did you report this injury to? _____ Position: _____
Did anyone else observe the accident/injury? □ Yes □ No If yes, Name: _____ Position: _____

SYMPTOMS FROM ACCIDENT

Did you experience bleeding, cuts, or bruises? □ Yes □ No
If bleeding or cuts, where? _____ If bruises, where? _____

Describe how you felt. Please be specific.
Immediately after the incident: _____ Later that day: _____ Later that night: _____
The next day(s): _____

Please check (√) all symptoms that have become apparent since the accident/injury.

□Nervousness	□Loss of balance	□Sleeping trouble	□Headache
□Neck pain/stiffness	□Loss of smell	□Toe numbness	□Fainting
□Midback pain	□Loss of taste	□Finger numbness	□Anxiety
□Low back pain	□Loss of memory	□Cold hands	□Seizures
□Eyes sensitive to light	□Loss of bladder control	□Cold feet	□Visual disturbance
□Pain behind eyes	□Pins and needles – arms	□Chest pain	□Forgetfulness
□Dizziness	□Pins and needles-legs	□Constipation	□Blurred vision
□Cold sweats	□Shortness of breath	□Diarrhea	□Double vision
□Face flushed	□Head seems too heavy	□Fatigue	□Confused
□Ringing/buzzing ears	□Irritability	□Tension	□Disoriented
□Fever	□Depression	□Other _____	

MECHANISM OF INJURY

Please explain the mechanism of injury (only fill in those sections that apply to you).
□**FALL**

□Yes □No Did you hit anything when you fell? If yes. what? _____
□Yes □No Were you carrying anything when you fell? If yes, what?
How much did weigh? _____lbs.
□Yes □No Did you twist when you fell? If so, to which side? □Left □Right
□Yes □No Was the area/room lighted?

Describe the condition of the area (slippery, graveled, etc.) _____
What part of the body did you fall on? _____
How far did you fall? (in feet) _____
What did you land on? _____

☐**LIFT/PULL**

How much did the object weigh? _____lbs
☐Yes ☐No Did you fall after the injury? if yes, how far? _____
☐Yes ☐No Did you hit anything when you fell? If yes, what? _____
☐Yes ☐No Were you twisting when you were lifting/pulling? If yes, to which side? ☐Left ☐Right
How far off the ground did you have the object before the pain started? _____
☐Yes ☐No Did you drop the object when the pain started?
☐Yes ☐No If yes, did it land on you? Where?
Did you lift With your ☐ Legs ☐Back ☐Other: _____
☐Yes ☐No Were you lifting when you were bent over? If yes, how much did the object weigh? _____ lbs.
How far were you bent over? _____

☐Yes ☐No Did you fall when the pain started? How far? _____
☐Yes ☐No Were you twisting when you bent forward? Toward which side? ☐Left ☐Right
☐Yes ☐No Did you land on anything? If so, what? _____

☐**OTHER** Describe mechanism in detail:

WORK STATUS

☐Yes ☐No Have you lost time from work due to this new injury? If yes, please give dates. From: _____ To: _____
☐Yes ☐No Have you returned to work? If yes, date returned: _____

If you have returned to work, in what capacity are you currently working? ☐Modified ☐Regular (no restrictions)
If you have returned to work, list any activities that are:
PAINFUL _____
DIFFICULT _____

If you have not returned to work, please indicate why: _____
_____

COURSE OF TREATMENT TO DATE

☐Yes ☐No Were you hospitalized as a result of this accident? If yes, where?_____

First Doctor's Name/location: _____ Type of Doctor: _____ Date of First Visit: _____

☐Yes ☐No Were you examined? ☐Yes ☐No Were x-rays taken?
What diagnosis did the doctor give you? _____
☐Yes ☐No Were you given treatment? If yes, what type? _____
What benefits did you receive from this treatment? _____
Date of last treatment: _____
☐Yes ☐No Did the doctor refer you to another health professional? If yes, to whom and for what? _____
☐Yes ☐No Did you follow the doctor's recommendations? If no, why not? _____

Second Doctor's Name/location: _____ Type of Doctor: _____ Date of First Visit: _____

☐Yes ☐No Were you examined? ☐Yes ☐No Were x-rays taken?
What diagnosis did the doctor give you? _____
☐Yes ☐No Were you given treatment? If yes, what type? _____
What benefits did you receive from this treatment? _____
Date of last treatment: _____
☐Yes ☐No Did the doctor refer you to another health professional? If yes, to whom and for what? _____
☐Yes ☐No Did you follow the doctor's recommendations? If no, why not? _____

PRIOR SIMILAR SYMPTOMS

☐Yes ☐No Did you have any physical complaints just before the accident? If yes, please describe in detail: _____
_____
_____

☐Yes ☐No Have you ever had any prior injuries, accidents, diseases, or treatments to the area of your body *now affected*?
If yes, what part was previously injured? _____ Date of previous injury: _____
Describe that injury: _____

☐Yes ☐No Were you treated for that injury? If yes, by whom? _____
Date treatment began: _____ Date treatment ended: _____
The last date you felt pain or problems from that injury: _____

YOUR JOB DESCRIPTION

In a typical 8-hour workday, circle the number of hours of activity you perform:

Sitting	1	2	3	4	5	6	7	8	Hours
Standing	1	2	3	4	5	6	7	8	Hours
Walking	1	2	3	4	5	6	7	8	Hours

For a typical 8-hour workday, refer to the following: **Occasionally = 33%** **Frequently = 34% to 66%** **Continuously = 67% to 100%**

On the job, I perform this activity	Not at all	Occasionally	Frequently	Continuously
Bend/Stoop	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Reach Above Shoulder Level	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Pull/Push	☐	☐	☐	☐
Drive Machinery/Automotive Equipment	☐	☐	☐	☐

On the job, I lift	Not at all	Occasionally	Frequently	Continuously
Up to 10 pounds	☐	☐	☐	☐
11 to 24 pounds	☐	☐	☐	☐
25 to 34 pounds	☐	☐	☐	☐
35 to 50 pounds	☐	☐	☐	☐
51 to 74 pounds	☐	☐	☐	☐
75 to 100 pounds	☐	☐	☐	☐

☐Yes ☐No Are you required to bend over while doing any lifting?
☐Yes ☐No Are your feet used in repetitive movements, such as operating foot controls?

☐Yes ☐No Do you use your hands for repetitive actions such as
simple grasping ☐Yes ☐No Firm grasping ☐Yes ☐No Fine Manipulating ☐Yes ☐No
Are you right-hand dominant or left-hand dominant? ☐Right-handed ☐Left-handed
☐Yes ☐No Are you required to work at unprotected heights?

☐Yes ☐No Are you required to be around moving machinery?
☐Yes ☐No Are you exposed to marked changes in temperature and humidity?
☐Yes ☐No Are you required to drive automotive equipment? If yes, describe: _____
☐Yes ☐No Are you exposed to dust, flames, gases? If yes, describe: _____
Is there anything further you would like us to know? _____

Patient Signature: _____ Date: _____

For Office Use
Doctor's Notes: