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

#1014-N
MISSION PRINTING (209) 227-7640

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: _____

_____

CONTINUED

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	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐

OVER

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Crouch	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Balancing	☐	☐	☐	☐
Pushing / Pulling	☐	☐	☐	☐

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	☐	☐	☐	☐

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	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Left hand	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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