

WORKER'S COMPENSATION INJURY QUESTIONNAIRE

Please Print:

Name: _____ Today's Date: _____

Employer's Business Name at time of Accident: _____

Employer's Phone: _____ Employer's Address _____

Occupation: _____

Yes No Previous Worker's Compensation Injury? Impairment Rating: _____

Length of time at this job prior to injury: _____

Date of Injury: _____ Time of injury: _____ Last Date Worked: _____

Please explain what you were doing at the time you were injured and how the accident happened (lifting, bending, walking, carrying standing, etc.) _____

When did the pain begin?(please be specific) _____

Where did you first feel it?(please be specific) _____

Was the pain intense at first or did it gradually worsen? _____

REPORT ACCIDENT/ACCIDENT OBSERVER

What date did you report this injury on? _____

Who did you report this injury to? _____ Position? _____

Did anyone else observe accident/injury? Yes No If yes, Name: _____
Position: _____

SYMPTOMS FROM ACCIDENT

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

Please describe how you felt. PLEASE BE SPECIFIC.

Immediately after the accident: _____

Later that Day Night: _____

The next day(s): _____

Check symptoms that have become apparent since the accident/injury:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Sleeping trouble | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Toe Numbness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Midback Pain | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Finger Numbness | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Eyes sensitive to light | <input type="checkbox"/> Pins & Needles - Arms | <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Visual disturbance |
| <input type="checkbox"/> Pain behind eyes | <input type="checkbox"/> Pins & Needles - Legs | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Forgetfulness |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Constipation | <input type="checkbox"/> Blurred Vision |
| <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Face flushed | <input type="checkbox"/> Irritability | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Confused |
| <input type="checkbox"/> Ringing/Buzzing Ears | <input type="checkbox"/> Depression | <input type="checkbox"/> Tension | <input type="checkbox"/> Disoriented |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Other _____ | | |

MECHANISM OF INJURY:

Please explain the mechanism of the 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 it weigh? _____ lbs.
- Yes No Did you twist when you fell? If so, to which side? Left Right
- Yes No Was the area 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 Did it land on you? Where? _____
- Did you lift with your Legs Back Other _____

BEND:

- 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? _____

WORK STATUS HISTORY:

- Yes No Have you lost time from work as a result of this new injury? If yes, please give dates: _____
- Yes No Have you gone back to work? When: _____
If yes, status or work: Modified Regular
List restrictions you have been placed on: _____
If you have gone back to work, list activities that are:
PAINFUL: _____
DIFFICULT: _____
- Yes No If you are currently on disability (time loss), do you want to go back to work doing your regular job?
If no, why not? _____
- Yes No Are there any problems you have with a fellow employee, supervisor, or manager that needs to be discussed? If yes, please explain: _____

FIRST DOCTOR/HOSPITAL/CLINIC:

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

Doctor 1 Name: _____ 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 recommendation? If no, why not? _____

SECOND DOCTOR/CLINIC:

Doctor 2 Name: _____ 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? _____

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 treatment to the area of your body now affected? If yes, what part was previously injured? _____
Date previously injured? _____
Describe previous injury: _____

Yes No Were you treated? By whom? _____
Date treatment began: _____ Date treatment ended: _____
The last date you felt pain or problems from that previous injury: _____

PLEASE SEE PAGE 4 FOR JOB DESCRIPTION

JOB DESCRIPTION

In terms of an 8 - hour workday: **Occasionally** = 33%, **Frequently** = 34% to 66%, **Continuously** = 67% to 100%

In a typical 8 - hour workday, I (circle the number of hours of activity):

Sit	1	2	3	4	5	6	7	8	Hours
Stand	1	2	3	4	5	6	7	8	Hours
Walk	1	2	3	4	5	6	7	8	Hours

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/>
Pulling/Pushing	<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"/>

- 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?

Do you use your hands for repetitive actions such as:

	Simple Grasping	Firm Grasping	Find 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

- Yes No Are you required to work at unprotected heights? If yes, please describe: _____

Yes No Are you required to be around moving machinery? If yes, please describe: _____

Yes No Are you exposed to marked changes in temperature and humidity? If yes, please describe: _____
Yes No Are you required to drive automotive equipment? If yes, please describe: _____

Yes No Are you exposed to dust, flames, and/or gases? If yes, please describe: _____

Please list any additional comments: _____

Patient's Signature: _____ Date: _____