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 _____

SAMPLE

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: ______________

____

SAMPLE

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:

____

____

____

____

SAMPLE

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

SAMPLE