

Workers Compensation History

Patient Name: _____ Phone #: _____

Home Address: _____

Age: _____ DOB: _____ Sex: Male / Female SSN: _____

Employers Name: _____ Phone #: _____

Employer Address: _____

Name of Compensation Carrier: _____ Phone #: _____

1. Type of Business: _____ Your Occupation: _____

2. Date of Injury: _____ Time: _____ am/pm Last date worked _____ Are you off work Yes No

3. Is this a previous workers compensation injury? Yes No

4. Was this accident reported to your employer? Yes No If yes to whom: _____

5. Injured at: _____ City: _____ State: _____ Zip: _____

6. Length of time worked at above employer prior to the accident? _____

7. Type of work being done at the time of injury? _____

8. In your own words, please describe the accident: _____

9. Have you been treated by another doctor for this accident? Yes No

10. If yes, please list doctors name and address: _____

What type of treatment did you receive? _____ For how long? _____

11. Are you: Improved Unchanged Getting Worse

12. What type of medications are you taking? _____

Do the medicine help? Yes No Unsure

13. Have you had physical therapy? Yes No

If yes, how often? Daily Ever other day Multiple times week Ever other week Weekly

Other: _____ Did the PT help you? Yes No Unsure

14. Prior to the accident, have you ever had any of the physical complaints similar to what you have now?

Yes No Unsure If yes, describe: _____

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

Please provide details of accident(s): _____

15. Have you had any serious accidents, which required medical care? Yes No

If yes, please explain: _____

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

If yes, please explain: _____

17. Have you had surgeries? Yes No

If yes, type and date: _____

18. Have you had any nervous or mental illness? Yes No

Have you had psychiatric care? Yes No

19. Have you had a medical discharge from the Armed Forces Yes No

20. Have you returned to work since the accident? Yes No

If you have returned to work since your accident, please fill out the information below:

<u>DATE</u>	<u>Employer</u>	<u>Occupation</u>	<u>Light or Regular Duty</u>	<u>Full/ Part Time</u>

Current Medical Complaints

Back Pain

1. Currently I have pain in my: Low Back Mid Back Upper Back
2. My pain began: Gradually Suddenly
3. I have pain: Sometimes All of the time
4. My pain goes into my: Right Leg Left Leg Both
5. I have tingling and/ or numbness in my: Right Leg Left Leg Both
6. My Pain is worse when I: (check all that apply)
 Cough/Sneeze Sit Bend Walk Lift Push Pull None of these
7. My back pain is worse with sexual activity? Yes No
8. My pain wakes me up during the night? Yes No
9. Do changes in the weather affect your pain? Yes No

Neck Pain

1. My pain began: Gradually Suddenly
2. I have pain: Sometimes All of the time
3. My pain goes into my: Right Arm Left Arm Both
4. I have tingling and / or numbness in my: Right Arm Left Arm Both
5. My pain is worse when I: (check all that apply)
 Cough/Sneeze Bend Forward Walk Lift Push Pull Turn My Head None
6. My Pain wakes me up during the night: Yes No
7. Changes in the weather affect my pain: Yes No
8. I have neck stiffness: Yes No
9. I have headaches: Yes No
If yes, how often do they occur? Sometimes All of the time Other: _____

Other Pain

Please describe any current medical complaint(s) which you are experiencing and were not previously covered on the questionnaire, or list any additional comments you wish to make regarding your condition.

Job Description

(In terms of an 8-hour workday, "occasionally" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day).

1. In a typical 8-hour workday, I: (check # of hours / activity totaling 8 hours)

	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>
<u>Sit</u>								
<u>Stand</u>								
<u>Walk</u>								

2. On the job, I perform the following activities: (check all that apply)

<u>Activity:</u>	<u>Not At All</u> 0%	<u>Occasionally</u> 33%	<u>Frequently</u> 34%-66%	<u>Continuously</u> 67%-100%
<u>Bend/Stoop</u>				
<u>Squat</u>				
<u>Crawl</u>				
<u>Climb</u>				
<u>Reach over Shoulder level</u>				
<u>Crouch</u>				
<u>Kneel</u>				
<u>Balancing</u>				
<u>Push/Pull</u>				

3. On the job I lift: (check all that apply)

	<u>Not At All</u> 0%	<u>Occasionally</u> 33%	<u>Frequently</u> 34%-66%	<u>Continuously</u> 67%-100%
Up to 10 lbs				
11-24 lbs				
24-34 lbs				
35-50 lbs				
51-74 lbs				
75-100 lbs				

4. Do you have to bend over while lifting? Yes No

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

If yes, explain: _____

6. Do you use your hands for repetitive actions, such as: Yes No

If yes, check the boxes that applies below

	<u>Simple Grasping</u>	<u>Firm Grasping</u>	<u>Fine Manipulating</u>
<u>Right Hand</u>			
<u>Left Hand</u>			

7. Are you required to work on up protected heights? Yes No

If yes, explain: _____

8. Are you required to be moving around moving machinery? Yes No

If yes, explain: _____

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

If yes, explain: _____

10. Are you required to drive automotive equipment? Yes No

If yes, explain: _____

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

If yes, explain: _____

12. Please list and additional comments: _____

Signature: _____

Date: _____