

WORK COMP HISTORY

Patient _____ Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ S/S # _____

Name of Compensation Carrier: _____ Phone _____

Address of Carrier: _____ City _____ State _____ Zip _____

Employer's Name: _____ Phone _____

Employer's Address: _____ City _____ State _____ Zip _____

1. Type of Business _____ Your Occupation _____

2. Date Injured _____ Hour _____ AM/PM Last Date Worked _____ Are you off work? Y/N

3. Accident Reported to Employer? () Yes () No Name of person reported to _____

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

5. Length of time worked prior to accident: _____

6. Type of work being done at time of injury: _____

7. In your own words, please describe accident: _____

8. 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? _____

9. Are you: () Improved () Unchanged () Getting worse

10. What types of medications are you taking? _____

Do these medications help? () Yes () No () Don't know

11. Have you had physical therapy? () Yes () No If yes, how often? _____

Does the physical therapy help? () Yes () No () Don't know

12. Prior to this accident, have you ever had any physical complaint similar to what you have now?

() Yes () No If yes, please describe: _____

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

Details of previous accident: _____

13. Have you returned to work since this accident? () Yes () No

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 the time | |
| 4. My pain goes into my: | () Right Leg | () Left Leg | () Both Legs |
| 5. I have tingling and/or numbness in my: | () Right Leg | () Left Leg | () Both Legs |
| 6. My pain is worse when I: | | | |
| cough or sneeze | () Yes | () No | |
| sit | () Yes | () No | |
| bend | () Yes | () No | |
| walk | () Yes | () No | |
| lift | () Yes | () No | |
| push | () Yes | () No | |
| pull | () Yes | () No | |
| 7. My back pain wakes me up during the night | () Yes | () No | |
| 8. Changes in weather affect my pain | () Yes | () No | |

NECK PAIN:

- | | | | |
|---|---------------|---------------------|----------|
| 1. My neck 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: | | | |
| cough or sneeze | () Yes | () No | |
| bend forward | () Yes | () No | |
| lift | () Yes | () No | |
| push | () Yes | () No | |

- pull () Yes () No
- turn my head () Yes () No
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
10. If I do get headaches, they occur: () Sometimes () All of the time

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:

(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: (Circle #of hours/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

2. On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend/stoop	()	()	()	()
Squat	()	()	()	()
Crawl	()	()	()	()
Climb	()	()	()	()
Reach above				
Shoulder level	()	()	()	()
Crouch	()	()	()	()
Kneel	()	()	()	()
Balancing	()	()	()	()
Pushing/Pulling	()	()	()	()

3. 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 () () () ()

4. Do you have to bend over while doing any lifting: () Yes () No

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

6. Do you use your hands 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

7. Are you required to work on unprotected heights? () Yes () No

Describe: _____

8. Are you required to be around moving machinery: () Yes () No

Describe: _____

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

Describe: _____

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

Describe: _____

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

Describe: _____

12. Please list any additional comments: _____

Signature: _____ Date: _____