

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? () Yes () No
3. Previous Workers Compensation Injury? () Yes () No
4. Accident reported to employer? () Yes () No Name of person reported accident to _____
5. Injured at: _____ City _____ State _____ Zip _____
6. Length of time worked there prior to accident: _____
7. Type of work being done at time of injury: _____
8. In your own words, please describe accident: _____

9. Have you been treated by another doctor for this accident? () Yes () No
If yes, please list doctors name and address: _____

What type of treatment did you receive? _____
How long were you treated by this doctor? _____
10. Are you: () improved () unchanged () getting worse
11. What types of medicines are you taking? _____

Do these medicines help? () Yes () No () Don't know
12. 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
13. Prior to this accident, have you ever had any physical complaints similar to what you have now?
() Yes () No () Don't know
If yes, describe: _____

Were these similar complaints the result of previous accident(s)? () Yes () No
Please provide details of accident(s): _____

14. Have you had any other serious accidents which required medical care? () Yes () No

Describe: _____

15. Have you had any serious illnesses that required hospitalization? () Yes () No

Describe: _____

16. Have you had any surgeries? () Yes () No

If yes, list type of surgery and date: _____

17. Have you had any nervous or mental illness? () Yes () No

Have you ever had psychiatric care? () Yes () No

18. Have you received medical discharge from the Armed Forces? () Yes () No

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

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

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY REGULAR DUTY	FULL-TIME PART-TIME

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:

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 is worse with sexual activity () Yes () No

8. My pain wakes me up during the night () Yes () No

9. Changes in the 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: _____