

WORK COMP HISTORY

Patient: _____ Phone: () _____ - _____
Address: _____ City: _____ State: _____ Zip: _____
Age: _____ Birthdate: ____/____/____ Sex: _____ SS#: _____ - _____ - _____
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 to: _____
5. Injured at: _____ City: _____ State: _____ Zip: _____
6. Length of time worked there prior to accident: _____
7. Type of work done at the 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 the doctor's 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 type 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 () Monthly () Every other week () Other _____
Does the physical therapy help? () Yes () No () Don't Know
13. Prior to this accident, have you ever had any of the physical complaints, pain or injuries to the same area similar to what you have now?
() Yes () No () Don't Know If yes, please describe: _____

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

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

If yes, please describe: _____

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

If yes, 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 had any psychiatric care? () Yes () No

18. Have you received a 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 REG. DUTY	FULL-TIME PART-TIME

CURRENT MEDICAL COMPLAINTS

Back Pain:

1. Currently, I have pain in my: () toe () foot () ankle () lower Leg () knee
 () hip () shoulder () upper arm () elbow () wrist
 () hand () finger(s) () neck () mid back () lower back
 () Other _____
- Currently, my pain is on () the right () the left () both sides
2. My pain began () gradually () suddenly
3. I have pain () sometimes () all of the time
4. My pain wakes me up at night () yes () no () sometimes
5. Changes in the weather affect my pain () yes () no
6. My pain goes to my () right leg () left leg () both legs () neither leg
 () right arm () left arm () both arms () neither arm
7. I have tingling and/or numbness in my:
 () right leg () left leg () both legs () neither leg
 () right arm () left arm () both arms () neither arm
 () right hand () left hand () both hands () neither hand
 () Other _____
 () I have no tingling or numbness.

8. My pain is worse when I:

- | | | | |
|-----------------|---------|--------|--|
| cough or sneeze | () Yes | () No | () no pain is experienced when doing this |
| Sit | () Yes | () No | () no pain is experienced when doing this |
| Bend forward | () Yes | () No | () no pain is experienced when doing this |
| Bend backward | () Yes | () No | () no pain is experienced when doing this |
| Walk | () Yes | () No | () no pain is experienced when doing this |
| Lift | () Yes | () No | () no pain is experienced when doing this |
| Push | () Yes | () No | () no pain is experienced when doing this |
| Pull | () Yes | () No | () no pain is experienced when doing this |

9. I have neck stiffness: () Yes () No

10. I have headaches: () Yes () No

11. 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:

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 0%	Occasionally 1 - 33%	Frequently 34 - 66%	Continuously 67 - 100%
Bend/stoop	()	()	()	()
Squat	()	()	()	()
Crawl	()	()	()	()
Climb	()	()	()	()
Reach above shoulder level	()	()	()	()
Crouch	()	()	()	()
Kneel	()	()	()	()
Balancing	()	()	()	()
Pushing / pulling	()	()	()	()

Not at all 0%	Occasionally 1 - 33%	Frequently 34 - 66%	Continuously 67 - 100%
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3. On the job, I lift:

up to 10lbs	()	()	()	()
11 to 24lbs	()	()	()	()
25 to 34lbs	()	()	()	()
35 to 50lbs	()	()	()	()
51 to 74lbs	()	()	()	()
75 to 100lbs	()	()	()	()

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

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

6. Do you use your hands for repetitive actions, such as:

	Simple grasping	Firm grasping	Fine manipulating
Right hand	()	()	()
Left hand	()	()	()

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

If yes, describe: _____

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

If yes, describe: _____

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

If yes, describe: _____

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

If yes, describe: _____

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

If yes, describe: _____

12. Please list any additional comments: _____

Signature: _____ Date: ____/____/____