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Workers Comp Health History Questionnaire

Date of first visit: _____

Name _____ Date of Birth_____

Address _____
(Street) (City) (State) (Zip code)

Phone _____ Sex __ Age ____
(Home) (Work) (Cell)

Height_____ Weight _____ Marital Status: _____

Occupation: _____ Employer:_____ Employer's Phone: _____

Employer's Address: _____ _____

Family Physician _____ Referring Physician _____

Work Comp Insurance Carrier _____ Claim # _____ Insurance phone #:_____

History of work injury:

1) Date of Injury _____
2) Previous Worker's Compensation Injury ? ( ) yes ( ) no
3) Accident reported to employer? ( ) yes ( ) no
4) Injured at: _____City _____ State _____
5) Length of time worked there prior to accident: _____
6) Type of work being done at time of injury: _____
   _____
7) In your own words, please describe accident and injury: _____
   _____
   _____
   _____
8) Have you been treated by another doctor for this injury? ( ) 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? ( ) Daily ( ) Every other day ( ) Several times a week ( ) Weekly ( ) Every other week
    ( ) Monthly ( ) Other: _____
    Does the physical therapy help? ( ) yes ( ) no ( ) don't know

12) Prior to this accident, have you ever had any physical complaints similar to what you have now? ( ) yes ( ) no
If yes, please describe: _____
_____
Were these similar complaints the results of a previous accident(s) ( ) yes ( ) no
Please provide details of accident(s) : _____
_____

13) Have you had any other serious accidents which required medical care? ( ) yes ( ) no
If yes, please describe: _____
_____

14) Have you had any serious illnesses that required hospitalization? ( ) yes ( ) no
If yes, please describe: _____
_____

15) Have you had any surgeries? ( ) yes ( ) no
If yes, list type of surgery and date: _____
_____
_____

16) Have you returned to work since this accident? ( ) yes ( ) no
If yes, please list date returned to work and describe any modifications to your work duties as a result of this injury: _____
_____
_____

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 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 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 arms
4)	I have tingling and/or numbness in my:	( ) right arm	( ) left arm	( ) both arms
5)	My pain is worst when I:			
	cough or sneeze	( ) yes	( ) no	
	bend forward	( ) yes	( ) no	
	turn my head	( ) yes	( ) no	
	lift	( ) yes	( ) no	
	push	( ) yes	( ) no	
	pull	( ) 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

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

	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 25 pounds	( )	( )	( )	( )
26 to 35 pounds	( )	( )	( )	( )
36 to 50 pounds	( )	( )	( )	( )
51 to 75 pounds	( )	( )	( )	( )
76 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 gasses? ( ) yes ( ) no
Describe: _____

12) Please list any additional comments: _____

_____

_____

Signature: _____ Date: _____