

## Worker's Compensation Injury Questionnaire

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Employer's Business Name at time of Accident: \_\_\_\_\_

Employer's Phone #: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Worker's Compensation Carrier:** \_\_\_\_\_ **Claim #:** \_\_\_\_\_

Previous Worker's Compensation Injury? Yes  No  Impairment rating: \_\_\_\_\_

Length of time at this job prior to injury: \_\_\_\_\_

**Date of Injury:** \_\_\_\_\_ **Time of Injury:** \_\_\_\_\_ **Last Day Worked:** \_\_\_\_\_

**Please explain what you were doing at the time you were injured and how the accident happened (lifting, bending, walking, carrying, standing, etc.):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When did the pain begin? (Please be specific): \_\_\_\_\_

Where did you feel it? (Please be specific): \_\_\_\_\_

Was the pain intense at first or did it gradually worsen? \_\_\_\_\_

### REPORT ACCIDENT

What date did you report this injury on? \_\_\_\_\_

Who did you report this injury to? \_\_\_\_\_ Position? \_\_\_\_\_

Did anyone else observe accident/injury? Yes  No

If yes, name: \_\_\_\_\_ Position? \_\_\_\_\_

### SYMPTOMS FROM ACCIDENT

Did you experience bleeding, cuts, or bruises? Yes  No

If bleeding or cuts, where? \_\_\_\_\_ If bruises, where? \_\_\_\_\_

Please describe how you felt. Please be specific.

Immediately after the accident: \_\_\_\_\_

Later that  day  night : \_\_\_\_\_

The next day(s): \_\_\_\_\_

Check symptoms that have become apparent since the accident/injury:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Nervousness             | <input type="checkbox"/> Loss of balance        | <input type="checkbox"/> Sleeping trouble | <input type="checkbox"/> Headache            |
| <input type="checkbox"/> Neck pain/stiffness     | <input type="checkbox"/> Loss of smell          | <input type="checkbox"/> Toe numbness     | <input type="checkbox"/> Fainting            |
| <input type="checkbox"/> Mid-back pain           | <input type="checkbox"/> Loss of taste          | <input type="checkbox"/> Finger numbness  | <input type="checkbox"/> Anxiety             |
| <input type="checkbox"/> Low back pain           | <input type="checkbox"/> Loss of memory         | <input type="checkbox"/> Cold hands       | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Eyes sensitive to light | <input type="checkbox"/> Tingling in arms/hands | <input type="checkbox"/> Cold feet        | <input type="checkbox"/> Visual disturbances |
| <input type="checkbox"/> Pain behind eyes        | <input type="checkbox"/> Tingling in legs/feet  | <input type="checkbox"/> Chest pain       | <input type="checkbox"/> Forgetfulness       |
| <input type="checkbox"/> Dizziness               | <input type="checkbox"/> Shortness of breath    | <input type="checkbox"/> Constipation     | <input type="checkbox"/> Blurred vision      |
| <input type="checkbox"/> Cold sweats             | <input type="checkbox"/> Head seems too heavy   | <input type="checkbox"/> Diarrhea         | <input type="checkbox"/> Double vision       |
| <input type="checkbox"/> Face flushed            | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Fatigue          | <input type="checkbox"/> Confused            |
| <input type="checkbox"/> Ringing/buzzing in ears | <input type="checkbox"/> Depression             | <input type="checkbox"/> Tension          | <input type="checkbox"/> Disoriented         |
| <input type="checkbox"/> Fever                   | <input type="checkbox"/> Other: _____           |   |  |

**MECHANISM OF INJURY**

Please explain the mechanism of injury (*Only fill in those sections that apply to you.*)

**FALL**

Yes  No Did you hit anything when you fell? If yes, what? \_\_\_\_\_

Yes  No Were you carrying anything when you fell? If yes, what? \_\_\_\_\_  
 How much did it weigh? \_\_\_\_\_ lbs.

Yes  No Did you twist when you fell? If so, to which side?  Left  Right

Yes  No Was the area lighted?

Describe the condition of the area (slippery, graveled, etc.): \_\_\_\_\_

What part of the body did you fall on? \_\_\_\_\_

How far did you fall? (in feet) \_\_\_\_\_

What did you land on? \_\_\_\_\_

**LIFT/PULL**

How much did the object weigh? \_\_\_\_\_ lbs.

Yes  No Did you fall after the injury? If yes, how far? \_\_\_\_\_

Yes  No Did you hit anything when you fell? If yes, what? \_\_\_\_\_

Yes  No Were you twisting when you were lifting/pulling? If yes, to which side?  Right  Left

How far off the ground did you have the object before the pain started? \_\_\_\_\_

Yes  No Did you drop the object when the pain started?

Yes  No Did it land on you? Where? \_\_\_\_\_

Did you lift with your  legs  Back  Other \_\_\_\_\_

**BEND**

Yes  No Were you lifting when you were bent over? If yes, how much did the object weigh? \_\_\_\_\_ lbs.

How far were you bent over? \_\_\_\_\_

Yes  No Did you fall when the pain started? If yes, how far? \_\_\_\_\_

Yes  No Were you twisted when you bent forward? Toward which side?  Right  Left

Yes  No Did you land on anything? If so, what? \_\_\_\_\_

**WORK STATUS HISTORY**

Yes  No Have you lost time from work as a result of this new injury? If yes, please give dates: \_\_\_\_\_

Yes  No Have you gone back to work? When? \_\_\_\_\_

If yes, status of work:  Modified  Regular

List restrictions you have been placed on: \_\_\_\_\_

If you have gone back to work, list activities that are:

PAINFUL: \_\_\_\_\_

DIFFICULT: \_\_\_\_\_

Yes  No If you are currently on disability (time loss), do you want to go back to work doing your regular job? If no, why not? \_\_\_\_\_

Yes  No Are there any problems you have with a fellow employee, supervisor, or manager that needs to be discussed? If yes, please explain: \_\_\_\_\_

**FIRST DOCTOR/HOSPITAL/CLINIC**

Yes  No Were you hospitalized as a result of this accident? If yes, where: \_\_\_\_\_

**Doctor 1 Name:** \_\_\_\_\_ **Date of First Visit:** \_\_\_\_\_

Yes  No Were you examined?

Yes  No Were x-rays taken? If yes, what area? \_\_\_\_\_

What diagnosis did the doctor give you? \_\_\_\_\_

Yes  No Were you given treatment? If yes, what type? \_\_\_\_\_

What benefits did you receive from this treatment? \_\_\_\_\_

\_\_\_\_\_

Date of last treatment? \_\_\_\_\_

Yes  No Did the doctor refer you to another health professional? If yes, to whom and for what?

Yes  No Did you follow the doctor's recommendation? If no, why not? \_\_\_\_\_

**SECOND DOCTOR/CLINIC**

**Doctor 2 Name:** \_\_\_\_\_ **Date of First Visit:** \_\_\_\_\_

Yes  No Were you examined?

Yes  No Were x-rays taken? If yes, what area? \_\_\_\_\_

What diagnosis did the doctor give you? \_\_\_\_\_

Yes  No Were you given treatment? If yes, what type? \_\_\_\_\_

What benefits did you receive from this treatment? \_\_\_\_\_

\_\_\_\_\_

Date of last treatment? \_\_\_\_\_

**PRIOR SIMILAR SYMPTOMS**

Yes  No Did you have any physical complaints just before the accident? If yes, please describe in detail:

\_\_\_\_\_

\_\_\_\_\_

Yes  No Have you ever had any prior injuries, accidents, diseases or treatment to the area of your body now affected? If yes, what part was previously injured? \_\_\_\_\_

\_\_\_\_\_

Date previously injured: \_\_\_\_\_

Describe previous injury: \_\_\_\_\_

Yes  No Were you treated? By whom? \_\_\_\_\_

Date treatment began: \_\_\_\_\_

Date treatment ended: \_\_\_\_\_

The last date you felt pain or problems from the previous injury: \_\_\_\_\_

\_\_\_\_\_

**JOB DESCRIPTION**

In terms of an 8-hour workday: *Occasionally* = 33%, *Frequently* = 34% to 66%, *Continuously* = 67% to 100%

**In a typical 8-hour workday, I** (circle the number of hours of 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

**On the job, I perform the following activities:**

	Not at all	Occasionally	Frequently	Continuously
Bend/Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above Shoulder Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling/Pushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**On the job, I lift:**

	Not at all	Occasionally	Frequently	Continuously
Up to 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 to 24 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25 to 34 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35 to 50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 to 74 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75 to 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Yes  No Are you required to bend over while doing any lifting?
- Yes  No Are your **feet** used in repetitive movements, such as operating foot controls?

Do you use your **hands** for repetitive actions such as:

	Simple grasping	Firm grasping	Fine manipulating
Right Hand	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Left Hand	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

- Yes  No Are you required to work at unprotected heights? If yes, please describe: \_\_\_\_\_
- Yes  No Are you required to be around moving machinery? If yes, please describe: \_\_\_\_\_
- Yes  No Are you exposed to marked changes in temperature and humidity? If yes, please describe: \_\_\_\_\_
- Yes  No Are you required to drive automotive equipment? If yes, describe: \_\_\_\_\_
- Yes  No Are you exposed to dust, flames, and/or gases? If yes, please describe: \_\_\_\_\_

Please list any additional comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_