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. May 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:** _____