Bradley H. Chesler MD, QME
Board Certified, Physical Medicine and Rehabilitation
Board Certified, Pain Medicine

Patient's Name: **DOI:**

WORKERS COMPENSATION PATIENT QUESTIONNAIRE

Date of Appointment:

Name:

Home Address: _____
(Please include city & zip code)

Telephone: HOME (____) _____ CELL: (____) _____

Date of Birth: _____ Age: _____ SSN #: _____

Marital Status: _____ Number of Children: _____ Ages: _____

Your Attorney's Name: (If applicable): _____

Interpreter's Name: (If applicable): _____

Are you right or left-handed? _____

INITIAL HISTORY OF INJURY

Did your injury occur at work? ( ) Yes ( ) No

Was your injury: **(Please select 1 or 2)**

1) _____A sudden **specific injury** from a sudden impact injury at work such as a trip and fall, sudden onset pain or trauma?
Complete pages 1 through 4 AND 8 through 22 Note: Skip pages 5 - 7

OR

2) _____A **cumulative trauma** resulting from sustained repetitive injury or exposure at work over a period of time?
Complete page 1 AND pages 5 through 22 Note: Skip pages 2 - 4

NOTE: Please complete the section below related to either your SPECIFIC INJURY HISTORY (Starts on Page 2) or CUMULATIVE TRAUMA INJURY (Starts on Page 4.) . It's not necessary to fill out both sections.

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SPECIFIC INJURY HISTORY

What part(s) of your body were injured? _____

What was the date(s) of injury? _____

Who was your employer at the time? _____

What was your occupation there? _____

How long had you been working there? _____

How did the Injury/Accident Happen? _____

_____

_____

Did anyone witness this injury? ( ) Yes ( ) No

Did you finish working? _____ Did you report the injury? _____

When? _____ To Whom? _____

Did you fill out a form? _____

What tasks did you do? _____

What tools or machines did you operate?_____

Where you exposed to: **(Check all that apply)**
( ) Chemicals ( ) Noise ( ) Fumes ( ) Smoke ( ) Mold ( ) Dust

During your work shift you were: **(Check one)**
( ) Mostly Sitting ( ) Mostly standing/walking ( ) Equal parts sitting an standing

What was the maximum weight you were required to lift by yourself? _____ lbs.

What is the typical weight you were required to lift by yourself? _____ lbs.

HISTORY OF INITIAL TREATMENT OF SPECIFIC INJURY

When did you first see a doctor? _____

Name of doctor: _____

Address: _____ City: _____

Who referred you to this doctor? _____

What tests were done? (Check appropriate tests below)

X-Ray_____ CT scan_____ NCV/EMG_____ Myelogram_____ Arthrogram____ MRI_____

Other:_____

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To what part of the body? _____

What treatment was suggested for your injury? (Check all that apply)

( ) Rest_____ Duration

( )Medications_____ Name of Medication

( ) Physical Therapy_____ Body Part/# of sessions

( ) Acupuncture_____ # of sessions

( ) Chiropractic_____ # of sessions

( ) Injections _____/_____ (body part/date) _____/_____ (body part/date)

( )Surgery_____

( )Hospitalization _____ Dates: _____

( )Other _____

( )None

What % of improvement did you feel with the above treatment(s)? _____ %

RETURN TO WORK FOLLOWING SPECIFIC INJURY

Have you returned to work since the injury? _____

Give date _____ Same Employer? _____

If different employer, give name: _____

Same job? _____ Full duty or restricted duty? _____

If restricted duty, list restrictions: _____

_____

Are you currently working? _____

If no, give last date of work: _____

Why did you stop working? _____

CONCURRENT EMPLOYMENT AT THE TIME OF INJURY

Did you have any other employment at the time of this injury? ( ) Yes ( ) No

If YES, please describe the job title and the tasks, physical demands, maximum weight lifted and equipment or machines you operated.

_____

_____

_____

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Patient's Name: **DOI:**

SUBSEQUENT ISSUES

Have you developed other problems as a result of this injury?

( ) Anxiety ( ) Stress ( ) Depression ( ) Insomnia ( ) Weight Gain ( ) Weight Loss

( ) Substance Abuse ( ) Other _____

Have you had any treatment for these other problems? ( ) Yes ( ) No

Have these problems resolved over time with treatment? ( ) Yes ( ) No

If YES, please describe: _____

_____

MEDICAL PROVIDERS SEEN FOR INJURY

List below any other doctors that you have seen for this injury. Starting with the one you saw after the doctor above and ending with the most recent doctor you have seen.

1. Name_____ Date Seen: _____

Who referred you to this doctor? _____

2. Name_____ Date Seen: _____

Who referred you to this doctor? _____

3. Name_____ Date Seen: _____

Who referred you to this doctor? _____

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CUMULATIVE TRAUMA HISTORY

What part(s) of your body were injured? _____

When did the symptoms begin? _____

Who was your employer at the time? _____

What was your occupation there? _____

How long were you working there? _____

What was the job duty that caused the injury?_____

What were your symptoms? _____

_____

Did you report the symptoms to anyone ? ( ) Yes ( ) No

If YES, who did you report it to? _____ Title:_____

Did you fill out a form? _____

HISTORY OF INITIAL TREATMENT OF CUMULATIVE TRAUMA INJURY

When did you first see a doctor? _____

Name of doctor: _____

Address: _____ City: _____

Who referred you to this doctor? _____

What tests were done? (Check appropriate tests below)

X-Ray_____ CT scan_____ NCV/EMG_____ Myelogram_____ Arthrogram____ MRI_____

Other_____

To what part of the body? _____

What treatment was suggested? (Check any appropriate)

( ) Rest_____ Duration

( )Medications_____ Name of Medication

( ) Physical Therapy_____ Body Part/# of sessions

( ) Acupuncture_____ # of sessions

( ) Chiropractic_____ # of sessions

( ) Injections _____/_____ (body part/date) _____/_____ (body part/date)

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Patient's Name: **DOI:**

( )Surgery_____

( )Hospitalization _____ Dates: _____

( )Other _____

( )None

What % of improvement did you feel with the above treatment(s)? _____ %

Names of other physicians seen for this injury: _____

_____

Were you placed on modified duty? ( ) Yes ( ) No

If YES, what were your restrictions and how long did the restrictions last?_____

_____

When were you off work as a result of this injury OR working with restrictions?

( ) Off work completely from _____ to _____ .

( ) Are you still off work completely? ( ) Yes ( ) No

( ) Working with restrictions from _____ to _____ .

Please describe your work restrictions: _____

_____

RETURN TO WORK FOLLOWING CUMULATIVE TRAUMA INJURY

Have you returned to work since the injury? _____

Give date _____ Same Employer? _____

If different employer, give name: _____

Same job? _____ Full duty or restricted duty? _____

If restricted duty, list restrictions: _____

_____

Are you currently working? _____

If no, give last date of work: _____

Why did you stop working? _____

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Patient's Name: **DOI:**

CONCURRENT EMPLOYMENT AT THE TIME OF INJURY

Did you have any other employment at the time of this injury? ( ) Yes ( ) No

If YES, please describe the job title and the tasks, physical demands, maximum weight lifted and equipment or machines you operated.

_____

_____

_____

SUBSEQUENT ISSUES

Have you developed other problems as a result of this injury?

( ) Anxiety ( ) Stress ( ) Depression ( ) Insomnia ( ) Weight Gain ( ) Weight Loss

( ) Substance Abuse ( ) Other _____

Have you had any treatment for these other problems? ( ) Yes ( ) No

Have these problems resolved over time with treatment? ( ) Yes ( ) No

If YES, please describe: _____

_____

List below any other doctors that you have seen for this injury. Starting with the one you saw after the doctor above and ending with the most recent doctor you have seen.

1. Name_____ Date Seen: _____

Who referred you to this doctor? _____

2. Name_____ Date Seen: _____

Who referred you to this doctor? _____

3. Name_____ Date Seen: _____

Who referred you to this doctor? _____

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Complete all remaining pages for either specific or cumulative injuries

JOB DESCRIPTION FOR EMPLOYER AT THE TIME OF INJURY

How many hours did you work per day? _____

How many days did you work per week? _____

What tasks did you do? _____

What tools or machines did you operate?_____

Where you exposed to: **(Check all that apply)**
( ) Chemicals ( ) Noise ( ) Fumes ( ) Smoke ( ) Mold ( ) Dust

During your work shift you were: **(Check one)**
( ) Mostly Sitting ( ) Mostly standing/walking ( ) Equal parts sitting an standing

What was the maximum weight you were required to lift by yourself? _____ lbs.

What is the typical weight you were required to lift by yourself? _____ lbs.

Which of the following did you perform **REPETITIVELY or CONSTANTLY**? (Please check all that apply)

( ) Tilting head up or down
( ) Kneeling/Squatting
( ) Writing/Typing
( ) Reaching Overhead
( ) Bending to the floor
( ) Climbing stairs or ladder
( ) Forceful gripping/grasping
( ) Assembly work using hands/arms
( ) Other _____

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JOB DESCRIPTION FOR EMPLOYER AT THE TIME OF INJURY (continued)

List your regular duties for the employer at the time you were injured: _____

_____

Check those that apply:	Number of Pounds Required:	% of day spent on this duty:
Lifting to chest level	_____	_____
Lifting above shoulder level	_____	_____
Pushing/Pulling	_____	_____
Carrying	_____	_____
Bending		_____
Squatting		_____
Kneeling		_____
Standing		_____
Sitting		_____
Driving		_____
Climbing		_____
Repetitive Hand Movements		_____

PRESENT COMPLAINTS

Do you have pain? _____ Where is it?_____

Are you currently receiving treatment for pain? ( ) Yes ( ) No

If YES, please describe treatment:_____

What does it feel like? (Sharp, dull, aching, stabbing, etc.) _____

Did any of these symptoms exist prior to your injury/illness? _____

Does your present pain travel to any other parts of the body? _____ Where? _____

How often does it occur? _____ What makes it worse? _____

What makes it better? _____

Is there any stiffness? _____ Where? _____

Is there any numbness? _____ Where? _____

Is there any tingling? _____ Where? _____

Is there any weakness? _____ Where? _____

Any swelling in joints? _____ Where? _____

Any grinding in joints? _____ Where? _____

Any locking in joints? _____ Where? _____

Any giving way of joints? _____ Where? _____

Are there any bowel or bladder problems? _____

Deformity/Scar? _____ Where? _____

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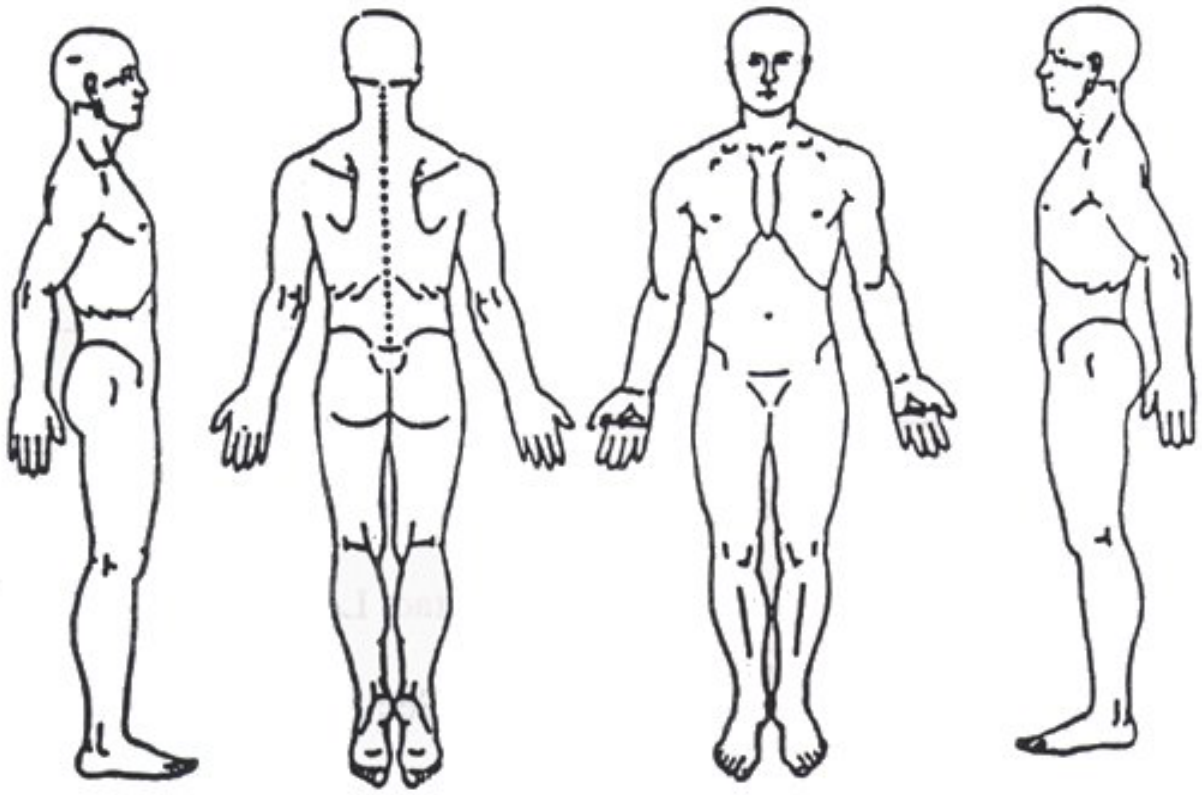
PAIN DIAGRAM

Using these pictures, indicate which parts of your body are affected by pain. Please use the symbols below:

N N N	Dull	/// /// ///	Stabbing / cutting
X X X	Burning	::::::::::::::	Tingling (pain & needles)
= = =	Numb	SSS	Cramping



PAIN RATING SCALE

Also, please circle which applies best:

PREVIOUS INJURIES: NOT RELATED TO WORK INJURY:

Have you had any accidents or injuries that are non-work-related injuries such as automobile accidents, sports injuries, and any other injuries sustained outside of the work environment? ( ) Yes ( ) No

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If no previous NON-INDUSTRIAL injuries, please proceed to "PREVIOUS INJURIES – WORK RELATED."

Non-industrial injury 1:

Date of injury: _____ What body part was involved: _____

How did the injury occur? _____

_____

Treatment type? _____

How long? _____ Symptoms resolved? _____

With whom did you treat? _____

Did you miss any time from work due to this injury? _____

How much time was lost? _____

Did you file a lawsuit as a result of the injury? ( ) Yes ( ) No

If YES, please describe:_____

_____

Did you have work restrictions, or did you limit your work activities in any way following the injury? ( ) Yes ( ) No

If YES, please describe: _____

_____

If YES, do you still have these restrictions in place? ( )Yes ( ) No

Non-industrial injury 2:

Date of injury: _____ What body part was involved: _____

How did the injury occur? _____

_____

Treatment type? _____

How long? _____ Symptoms resolved? _____

With whom did you treat? _____

Did you miss any time from work due to this injury? _____

How much time was lost? _____

Did you file a lawsuit as a result of the injury? ( ) Yes ( ) No

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Patient's Name: **DOI:**

If YES, please describe:_____

_____

Did you have work restrictions, or did you limit your work activities in any way following the injury? ( ) Yes ( ) No

If YES, please describe: _____

_____

If YES, do you still have these restrictions in place? ( )Yes ( ) No

PREVIOUS INJURIES – WORK RELATED

Have you ever had any other workers' compensation injuries? ( ) Yes ( ) No

If yes, please complete the following questions:

Previous Work-Related Injury 1:

Employer: _____ Date of Injury: _____

Occupation:_____

What part of the body was involved? _____

Did you report the injury? ( ) Yes ( ) No Who did you report to? _____

Job Duties/Tasks:_____

How did the injury/accident happen?_____

_____

Were you offered medical treatment? ( ) Yes ( ) No

Name of Doctor: _____

How long? _____ Symptoms resolved? _____

How much work time was lost? _____

What treatment was ordered/prescribed for this injury? (Check all that apply)

( ) Rest_____ Duration

( )Medications_____ Name of Medication

( ) Physical Therapy_____ Body Part/# of sessions

( ) Acupuncture_____ # of sessions

( ) Chiropractic_____ # of sessions

( ) Injections _____/_____ (body part/date) _____/_____ (body part/date)

( )Surgery_____

Patient's Name: **DOI:**

( )Hospitalization _____ Dates: _____

( )Other _____

( )None

What % of improvement did you feel with the above treatment(s)? _____ %

Were you placed on modified duty? ( ) Yes ( ) No

If YES, what were your restrictions?_____

_____

_____

Is the claim still open? ( ) Yes ( ) No

Was there an award or permanent disability from the injury? ( ) Yes ( ) No

Do you have formal work restrictions, or did you self-impose work restrictions following this injury? ( ) Yes ( ) No

If YES, please describe: _____

_____

_____

Previous Work-Related Injury 2:

Employer: _____ Date of Injury: _____

Occupation:_____

What part of the body was involved? _____

Did you report the injury? ( ) Yes ( ) No

Job Duties/Tasks:_____

How did the injury/accident happen?_____

_____

Were you offered medical treatment? ( ) Yes ( ) No

Name of Doctor: _____

How long? _____ Symptoms resolved? _____

How much work time was lost? _____

What treatment was ordered/prescribed for this injury? (Check all that apply)

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Patient's Name: **DOI:**

( ) Rest_____ Duration

( )Medications_____ Name of Medication

( ) Physical Therapy_____ Body Part/# of sessions

( ) Acupuncture_____ # of sessions

( ) Chiropractic_____ # of sessions

( ) Injections _____/_____ (body part/date) _____/_____ (body part/date)

( )Surgery_____

( )Hospitalization _____ Dates: _____

( )Other _____

( )None

What % of improvement did you feel with the above treatment(s)? _____ %

Were you placed on modified duty? ( ) Yes ( ) No

If YES, what were your restrictions?_____

_____

_____

Is the claim still open? ( ) Yes ( ) No

Was there an award or permanent disability from the injury? ( ) Yes ( ) No

Do you have formal work restrictions, or did you self-impose work restrictions following this injury? ( ) Yes ( ) No

If YES, please describe: _____

_____

_____

OCCUPATIONAL HISTORY

List most current employer to oldest. You may exclude the employer associated with the current injury.

PREVIOUS JOB TITLE 1:_____

Employer:_____

Dates of Employment: _____ to _____.

How many hours did you work per day? _____
How many days did you work per week? _____

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Patient's Name: **DOI:**

Job Description:

What tasks did you do? _____

What tools or machines did you operate?_____

Where you exposed to: **(Check all that apply)**
( ) Chemicals ( ) Noise ( ) Fumes ( ) Smoke ( ) Mold ( ) Dust

During your work shift you were: **(Check one)**
( ) Mostly Sitting ( ) Mostly standing/walking ( ) Equal parts sitting an standing

What was the maximum weight you were required to lift by yourself? _____ lbs.
What is the typical weight you were required to lift by yourself? _____ lbs.

Which of the following did you perform **REPETITIVELY or CONSTANTLY**? (Please check all that apply)

( ) Tilting head up or down
( ) Kneeling/Squatting
( ) Writing/Typing
( ) Reaching Overhead
( ) Bending to the floor
( ) Climbing stairs or ladder
( ) Forceful gripping/grasping
( ) Assembly work using hands/arms
( ) Other _____

PREVIOUS JOB TITLE 2:_____

Employer:_____

Dates of Employment: _____ to _____.

How many hours did you work per day? _____
How many days did you work per week? _____

Job Description:

What tasks did you do? _____

Patient's Name: **DOI:**

What tools or machines did you operate?_____

Where you exposed to: **(Check all that apply)**
( ) Chemicals ( ) Noise ( ) Fumes ( ) Smoke ( ) Mold ( ) Dust

During your work shift you were: **(Check one)**
( ) Mostly Sitting ( ) Mostly standing/walking ( ) Equal parts sitting an standing

What was the maximum weight you were required to lift by yourself? _____ lbs.
What is the typical weight you were required to lift by yourself? _____ lbs.

Which of the following did you perform **REPETITIVELY or CONSTANTLY**? (Please check all that apply)

( ) Tilting head up or down
( ) Kneeling/Squatting
( ) Writing/Typing
( ) Reaching Overhead
( ) Bending to the floor
( ) Climbing stairs or ladder
( ) Forceful gripping/grasping
( ) Assembly work using hands/arms
( ) Other _____

PREVIOUS JOB TITLE 3:_____

Employer:_____

Dates of Employment: _____ to _____.

How many hours did you work per day? _____
How many days did you work per week? _____

Job Description:

What tasks did you do? _____

What tools or machines did you operate?_____

Where you exposed to: **(Check all that apply)**
( ) Chemicals ( ) Noise ( ) Fumes ( ) Smoke ( ) Mold ( ) Dust

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During your work shift you were: **(Check one)**
( ) Mostly Sitting ( ) Mostly standing/walking ( ) Equal parts sitting an standing

What was the maximum weight you were required to lift by yourself? _____ lbs.
What is the typical weight you were required to lift by yourself? _____ lbs.

Which of the following did you perform **REPETITIVELY or CONSTANTLY**? (Please check all that apply)

( ) Tilting head up or down
( ) Kneeling/Squatting
( ) Writing/Typing
( ) Reaching Overhead
( ) Bending to the floor
( ) Climbing stairs or ladder
( ) Forceful gripping/grasping
( ) Assembly work using hands/arms
( ) Other _____

PAST MEDICAL HISTORY

Do you have a history of any of the following conditions?

High Blood Pressure	( ) Yes	( ) No	Describe: _____
Diabetes	( ) Yes	( ) No	Describe: _____
Cardiac (heart) Issues	( ) Yes	( ) No	Describe: _____
Pulmonary (lungs) Issues	( ) Yes	( ) No	Describe: _____
Renal (Kidney) Issues	( ) Yes	( ) No	Describe: _____
Gastrointestinal Issues	( ) Yes	( ) No	Describe: _____

ANY PREVIOUS ILLNESS OR MEDICAL CONDITIONS

_____

_____

_____

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PREVIOUS HOSPITALIZATIONS

Name of Hospital	Reason	Date
_____	_____	_____
_____	_____	_____

SURGICAL HISTORY

Operation	Surgeon and City	Date
_____	_____	_____
_____	_____	_____

CURRENT MEDICATIONS

List all medications you are now taking: _____
_____

ALLERGIES

Are you allergic to any food or medication? _____
What allergic reaction occurs? _____

MILITARY SERVICE

Dates of military service_____ Branch_____
Medical discharge? _____

SOCIAL HISTORY

Do you smoke? _____ How much? _____ How long? _____
Do you drink alcohol? _____ How much? _____ How long? _____
Recreational Drug Use: ( ) Yes ( ) No Type:_____ Frequency:_____
Sports and Hobbies_____

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REVIEW OF SYSTEMS

Circle any specific item in each section that applies to you and explain any YES answers in the space below the table.

		YES	NO
GENERAL	Fevers, chills, fatigue, unexpected weight loss, or weight gain		
EYES	Corrective lenses, blurry vision, redness, watering of the eyes, or eye pain?		
EARS, NOSE, THROAT (ENT)	Headaches, difficulty swallowing, nose bleeds, ringing in the ears, or earaches?		
CARDIOVASCULAR	Chest pain, palpitations, fainting or murmurs?		
RESPIRATORY	Shortness of breath, wheezing, coughing, tightness, inspiration pain, or snoring?		
GASTROINTESTINAL	Heartburn, stomach irritation, nausea, vomiting, constipation, diarrhea, or bloody/tarry stools?		
GENITOURINARY	Frequency and urgency, difficult/painful urination, flank pain, or bleeding?		
MUSCULOSKELETAL	Joint pain, muscle pain, stiffness, instability, swelling, redness, and heat?		
SKIN	Skin changes, poor healing, rash, itching, and redness?		
NEUROLOGIC	Numbness/Tingling, unsteady gait, dizziness, tremors, or seizures?		
PSYCHIATRIC	Anxiety, depression, or suicidal ideations?		
HEMATOLOGIC/LYMPHATIC	Easy bleeding or bruising?		
ENDOCRINE	Excessive thirst or urination, or heat/cold intolerance?		

PLEASE EXPLAIN EACH ON OF YOUR "YES" ANSWERS HERE:

_____

_____

_____

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FAMILY HISTORY

Have you or any member in your family been treated for the following?

	SELF	MOTHER	FATHER	BROTHER	SISTER
TUBERCULOSIS					
CANCER					
ARTHRITIS					
KIDNEY PROBLEMS					
ASTHMA					
HEART					
EPILEPSY					
OSTEOPOROSIS					
DIZZINESS					
ANXIETY					
MUSCULAR PROBLEMS					
HYPERTENSION					
BOWEL/BLADDER PROBLEMS					
EXCESSIVE BLEEDING					
DEPRESSION					
GYN (FEMALE)					
DIABETES					
OTHER_____					

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ACTIVITIES OF DAILY LIVING (ADLs)

Please review the listed ADLs. For each, place an "X" in the box which best describes your usual ability to perform the activity, **BEFORE THE INJURY**, and then **OVER THE PAST MONTH**

	BEFORE YOUR INJURY				OVER THE PAST MONTH			
ACTIVITY	No Difficulty	With Some Difficulty	With Difficulty	Unable	No Difficulty	With Some Difficulty	With Difficulty	Unable
Self-Care/Personal Hygiene - Can You:								
Take a bath/shower normally?								
Brush your teeth?								
Comb/Brush your hair?								
Eat & Drink?								
Get dressed without help?								
Urinate?								
Have a bowel movement?								
Communication - Can You:								
Write?								
Type on a keyboard?								
See clearly?								
Hear clearly?								
Speak clearly?								
Physical Activity - Can You:								
Stand?								
Walk?								
Sit?								
Recline/Lie down?								
Climb stairs?								
Sensory Function - Can You:								
Hear?								
See?								
Feel what you touch?								
Smell?								
Taste what you eat?								

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	BEFORE YOUR INJURY					OVER THE PAST MONTH			
ACTIVITY	No Difficulty	With Some Difficulty	With Difficulty	Unable		No Difficulty	With Some Difficulty	With Difficulty	Unable
Hand Function - Can You:									
Grasp something?									
Hold something?									
Lift a gallon of milk?									
Lift a child?									
Travel - Can You:									
Ride in a car?									
Drive a car?									
Fly in an airplane?									
Sexual Function - Can You									
Have sexual intercourse?									
Achieve orgasm?									
Sleep - Can You:									
Fall asleep?									
Maintain sleep?									

With my signature, I, _____ confirm that any information completed in this packet is true & accurate to the best of my ability.

Patient's Signature_____ Date: _____