Patient Questionnaire – Work-Accident

Patient Name: _____ Today's Date: ___/___/___

Date of Exam: ___/___/___ Provider: _____ New Patient ☐ Yes ☐ No

Basic Information about the Accident:

Date Accident Occurred or Started: ___/___/___ Time of Day when Accident Occurred or Started: ___:_____ AM / PM

Describe how the Accident took place: _____

_____

_____

_____

Describe the condition or symptoms caused by the Accident: _____

_____

_____

_____

Work-Accident Specific Information:

Check all that apply:

☐ Did the accident occur on the premises of the facility where you normally work (i.e., your local work address)?

☐ Did the accident occur during your normal working hours?

☐ Did you report the accident to your Employer?

☐ Is your Employer covered by Workers' Compensation Insurance under state law?

☐ Has your Employer prepared an initial written report?

☐ Does the Employer's Report describe the condition or symptoms you are experiencing?

☐ Has a claim number been issued for this accident?

☐ Have you received any written denial of liability from either your Employer or Worker's Insurance Comp Payer?

Additional Information Related to the Condition:

Describe your pain: ☐ Sharp ☐ Dull ☐ Stabbing ☐ Aching ☐ Radiating ☐ Burning ☐ Throbbing ☐ Numbness

What caused it? _____

What aggravates it? _____

What relieves it? _____

Has the Patient ever had the same or similar condition or symptoms previous to this most recent occurrence? ☐ Yes ☐ No

When? ___/___/___

Describe: _____

_____

_____

_____

Please indicated any other healthcare providers who the Patient has seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
_____	_____	___/___/___
_____	_____	___/___/___

Have you missed work or school due to your injuries? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Number of packs: _____

Do you drink alcohol? ☐ Yes ☐ No Number of Drinks _____

Notes: _____

_____

_____

_____

Medical History:

Have you ever been in our office before? ☐ Yes ☐ No

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1) _____ ___/___/___
2) _____ ___/___/___
3) _____ ___/___/___

Surgeries/Hospitalizations: _____

Allergies (please list all): _____

List all medications you are now taking and why: _____