WORK COMP HISTORY

Patient _____ Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ SS# _____

Name of Compensation Carrier _____ Phone _____

Carrier's Address _____ City _____ State _____ Zip _____

Employer's Name _____ Phone _____

Employer's Address _____ City _____ State _____ Zip _____

Type of Business _____ Your Occupation _____

Date Injured _____ Hour _____ AM/PM Last Date Worked _____ Are you off work? [ ]Yes [ ]No

Previous Workers' Compensation Injury [ ]Yes [ ]No

Accident reported to employer? [ ]Yes [ ]No Name of person reported accident to _____

Injured at: _____ City _____ State _____ Zip _____

Length of time worked there prior to accident: _____

Type of work being done at time of injury: _____

_____

In your own words, please describe the accident: _____

_____

_____

_____

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? _____

Are you: [ ]Improved [ ]Unchanged [ ]Getting Worse

What types of medicines are you taking? _____

Do these medicines help? [ ]Yes [ ]No [ ]Don't Know

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 physical therapy help? [ ]Yes [ ]No [ ]Don't Know

Prior to this accident, have you ever had any of the physical complaints similar to what you have now?

[ ]Yes [ ]No [ ]Don't Know

If yes, describe: _____

_____

_____

Were these similar complaints the results of a previous accident(s)? [ ]Yes [ ]No

Please provide details of accident(s): _____

_____

_____

_____

WORK COMP HISTORY (cont.)

Have you had any other serious accidents which required medical care? [ ]Yes [ ]No

Describe: _____

_____

Have you had any serious illnesses that required hospitalization? [ ]Yes [ ]No

Describe: _____

_____

Have you had any surgeries? [ ]Yes [ ]No

If yes, list type of surgery and date: _____

_____

_____

Have you had any nervous or mental illnesses? [ ]Yes [ ]No

Have you had psychiatric care? [ ]Yes [ ]No

Have you received a medical discharge from the Armed Forces? [ ]Yes [ ]No

Have you returned to work since this accident? [ ]Yes [ ]No

If you have returned to work since your accident, please fill out the information below:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY REGULAR DUTY	FULL-TIME PART-TIME

CURRENT MEDICAL COMPLAINTS

Back Pain:

Currently, I have pain in my:	[ ] low back	[ ] mid back	[ ] upper back
My pain began:	[ ] gradually	[ ] suddenly	
I have pain:	[ ] sometimes	[ ] all of the time	
My pain goes into my:	[ ] right leg	[ ] left leg	[ ] both
I have tingling and/or numbness in my:	[ ] right leg	[ ] left leg	[ ] both
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	
My back is worse with sexual activity:	[ ] yes	[ ] no	
My pain wakes me up during the night:	[ ] yes	[ ] no	
Changes in weather affect my pain:	[ ] yes	[ ] no	

WORK COMP HISTORY (cont.)

Neck Pain:

My neck pain began:	[ ] gradually	[ ] suddenly	
I have pain:	[ ] sometimes	[ ] all of the time	
My pain goes into my:	[ ] right arm	[ ] left arm	[ ] both
I have tingling and/or numbness in my:	[ ] right arm	[ ] left arm	[ ] both
My 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	
My pain wakes me up during the night:	[ ] yes	[ ] no	
Changes in the weather affect my pain:	[ ] yes	[ ] no	
I have neck stiffness:	[ ] yes	[ ] no	
I have headaches:	[ ] yes	[ ] no	
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)

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

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	[ ]	[ ]	[ ]	[ ]

WORK COMP HISTORY (cont.)

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	[ ]	[ ]	[ ]	[ ]

Do you have to bend over while doing any lifting? [ ]Yes [ ]No

Are your feet used for repetitive movements, such as operating foot controls? [ ]Yes [ ]No

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

Are you required to work on unprotected heights? [ ]Yes [ ]No

Describe: _____

_____

_____

Are you required to be around moving machinery? [ ]Yes [ ]No

Describe: _____

_____

_____

Are you exposed to marked changes in temperature and humidity? [ ]Yes [ ]No

Describe: _____

_____

_____

Are you required to drive automotive equipment? [ ]Yes [ ]No

Describe: _____

_____

_____

Are you exposed to dust, fumes, and/or gases? [ ]Yes [ ]No

Describe: _____

_____

_____

Please list any additional comments: _____

_____

_____

Signature: _____ **Date:** _____