WORKERS' COMPENSATION PATIENT QUESTIONNAIRE

Dear Patient/Injured Worker:

It is important in a workers' compensation case to establish a complete and accurate base of personal and historical information. This information often becomes a critical part of the decision making process in coming to final determinations or conclusions about your case. Therefore, **your help and cooperation in answering this questionnaire as completely and accurately as possible is necessary and appreciated**. This is very important to the people involved in handling your case and for you to receive appropriate and fair compensation.

PLEASE, REVIEW AND COMPLETE THIS PATIENT QUESTIONNAIRE. DOING THIS WILL SIGNIFICANTLY REDUCE YOUR TIME IN THE OFFICE. THE AMOUNT OF TIME, WHICH HAS BEEN SCHEDULED FOR YOUR APPOINTMENT, DOES TAKE INTO CONSIDERATION THAT THIS HAS BEEN DONE. THANK YOU VERY MUCH!

PHYSICIAN USE ONLY:

Evaluation Date: _____
Evaluation Began: _____ A.M. ____ P.M. _____
Evaluation Ended: _____ A.M. ____ P.M. _____

Employee Information

Name: _____ Age: _____ Date: _____
Address: (complete mailing address) _____
Phone No.: (____)_____ Date Of Birth: _____ Soc. Sec. No.: _____
__ Male __ Female * __ Right Handed __ Left Handed __ Both * Height: _____ Weight: _____

Employer Information: ***(Your Employer At The Time You Were Injured)***

Name Of Business: _____ Phone No.: (____) _____
Address: _____

Workers' Compensation Insurance Carrier Information:

Name: _____ Phone No.: (____) _____
Address: _____
Claims Representative: _____ Claim No.: _____

Information About Your Work Injury:

Date Of Injury: _____ Time The Injury Occurred: _____ ____ A.M. ____ P.M.
Date You Reported Your Injury To Your Employer/Supervisor: _____
Name Of Person You Reported Your Injury To: _____
Where Did Your Injury Occur? (Address Or Description Of Location): _____
_____

Attorney Information: ( ) Check If None

Name: _____ Phone No.: (____) _____
Address: _____

HISTORY OF THE INJURY:

Please Describe How Your Work Injury Occurred: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please List The Injured Body Parts, **As A Result Of Your Work Injury:**
_____

(<u>History Of The Injury</u> - continued)

How Did Your Symptoms Come On? ___ Suddenly ___ Gradually **If 'Gradually'**, Over What Period of Time? _____
_____
_____

When Did Your Realize/Know That You Were Injured? Explain: _____
_____
_____

<u>HISTORY OF TREATMENT:</u>

When Did You First Seek Treatment For Your Injury? Date: _____
Did Your Employer Send You For Treatment? ___ YES ___ NO
Did You Seek Treatment On Your Own? ___ YES ___ NO
'<u>INITIALLY</u>', Did You Go To A Hospital/Emergency Room? ___ YES ___ NO **<u>If 'YES',</u>** Answer The Questions Below. **<u>If 'NO',</u>** Go To The ***Name Of Doctor/Facility #1*** On This Page.
Name Of Hospital/ER? _____ City: _____
Were You Admitted To The Hospital? ___ YES ___ NO If 'YES', How Long? _____
Name Of Doctor(s) At The Hospital/ER Who Treated You? _____
Describe The Type Of Treatment &/Or Diagnostic Testing That Was Done: _____
_____
_____
What Did The Hospital Doctor(s) Say Was Wrong With You? _____
_____
Were You Told That You Would Need More Treatment? ___YES ___ NO If 'YES', Explain:
_____
Did The Doctor(s) Restrict Or Modify Your Work Activities? ___ YES ___ NO If 'YES', How?
_____

Please list **<u>ALL</u>** Doctors You Have Seen Regarding Your Work Injury. Please List Them In Chronological Order/***<u>The Order You Saw Them In:</u>***

Name Of Doctor/Facility #1: _____ City/Location:_____
Type Of Doctor (degree or specialty): _____
Describe Treatment And/Or Tests: _____
_____
What Did This Doctor Say Was Wrong With You? _____
_____
Date When Treatment Started: _____ Date When Treatment Stopped: _____
How Many Treatments/Visits Were There? _____ How Long Were The Treatments? _____
What Was The Result/Outcome Of The Treatment? _____
_____
Still Treating With This Doctor? ___ YES ___ NO If 'YES', How Often? _____
Did This Doctor Take You Off Work? ___ YES ___ NO If 'YES', Give Dates: _____

(Dr. #1 – continued)

Did This Doctor Restrict Or Modify Your Work Activities? ___ YES ___ NO If 'YES', How?

_____

Did This Doctor Say You Would Need More Treatment? ___ YES ___ NO If 'YES', Explain:

_____

Did This Doctor Refer You Anywhere Else? ___ YES ___ NO If 'YES', Where And Why?

_____

Name Of Doctor/Facility #2: _____ City/Location:_____

Type Of Doctor (degree or specialty): _____

Describe Treatment And/Or Tests: _____

_____

What Did This Doctor Say Was Wrong With You? _____

_____

Date When Treatment Started: _____ Date When Treatment Stopped: _____

How Many Treatments/Visits Were There? _____ How Long Were The Treatments? _____

What Was The Result/Outcome Of The Treatment? _____

_____

Still Treating With This Doctor? ___ YES ___ NO If 'YES', How Often? _____

Did This Doctor Take You Off Work? ___ YES ___ NO If 'YES', Give Dates: _____

Did This Doctor Restrict Or Modify Your Work Activities? ___ YES ___ NO If 'YES', How?

_____

Did This Doctor Say You Would Need More Treatment? ___ YES ___ NO If 'YES', Explain:

_____

Did This Doctor Refer You Anywhere Else? ___ YES ___ NO If 'YES', Where And Why?

_____

Name Of Doctor/Facility #3: _____ City/Location:_____

Type Of Doctor (degree or specialty): _____

Describe Treatment And/Or Tests: _____

_____

What Did This Doctor Say Was Wrong With You? _____

_____

Date When Treatment Started: _____ Date When Treatment Stopped: _____

How Many Treatments/Visits Were There? _____ How Long Were The Treatments? _____

What Was The Result/Outcome Of The Treatment? _____

_____

Still Treating With This Doctor? ___ YES ___ NO If 'YES', How Often? _____

Did This Doctor Take You Off Work? ___ YES ___ NO If 'YES', Give Dates: _____

Did This Doctor Restrict Or Modify Your Work Activities? ___ YES ___ NO If 'YES', How?

_____

Did This Doctor Say You Would Need More Treatment? ___ YES ___ NO If 'YES', Explain:

_____

Did This Doctor Refer You Anywhere Else? ___ YES ___ NO If 'YES', Where And Why?

_____

(History Of Treatment – continued)

Name Of Doctor/Facility #4: _____ City/Location:_____
Type Of Doctor (degree or specialty): _____
Describe Treatment And/Or Tests: _____
_____
What Did This Doctor Say Was Wrong With You? _____
_____
Date When Treatment Started: _____ Date When Treatment Stopped: _____
How Many Treatments/Visits Were There? _____ How Long Were The Treatments? _____
What Was The Result/Outcome Of The Treatment? _____
_____
Still Treating With This Doctor? ___ YES ___ NO If 'YES', How Often? _____
Did This Doctor Take You Off Work? ___ YES ___ NO If 'YES', Give Dates: _____
Did This Doctor Restrict Or Modify Your Work Activities? ___ YES ___ NO If 'YES', How?
_____
Did This Doctor Say You Would Need More Treatment? ___ YES ___ NO If 'YES', Explain:
_____
Did This Doctor Refer You Anywhere Else? ___ YES ___ NO If 'YES', Where And Why?
_____

Name Of Doctor/Facility #5: _____ City/Location:_____
Type Of Doctor (degree or specialty): _____
Describe Treatment And/Or Tests: _____
_____
What Did This Doctor Say Was Wrong With You? _____
_____
Date When Treatment Started: _____ Date When Treatment Stopped: _____
How Many Treatments/Visits Were There? _____ How Long Were The Treatments? _____
What Was The Result/Outcome Of The Treatment? _____
_____
Still Treating With This Doctor? ___ YES ___ NO If 'YES', How Often? _____
Did This Doctor Take You Off Work? ___ YES ___ NO If 'YES', Give Dates: _____
Did This Doctor Restrict Or Modify Your Work Activities? ___ YES ___ NO If 'YES', How?
_____
Did This Doctor Say You Would Need More Treatment? ___ YES ___ NO If 'YES', Explain:
_____
Did This Doctor Refer You Anywhere Else? ___ YES ___ NO If 'YES', Where And Why?
_____

Were Any Other Tests, Examinations, Treatments, or Therapy Done That Were Not Described Above? ___ YES ___ NO If 'YES', Please Describe What Was Done And What The Result Was: **(use the back of this page if necessary):** _____
_____
_____
_____

(History Of Treatment – continued)

Do You Treat Yourself? ___ YES ___ NO If 'YES', Please Explain How: _____
_____
_____

Are You Currently Taking Medication To Relieve The Effects Of This Injury? ___ YES ___ NO
If 'YES', Please Describe What You Take, (Prescription or Non-Prescription), How Much It Helps, How Often You Take It, Etc.: _____
_____
_____

Are You Currently Using A Brace, Support, Cane, Crutch(es), Wheelchair, TENS Unit, Or Other Aid Because Of The Effects Of This Injury? ___ YES ___ NO If 'YES', Please Describe Type And How Often It Is Used: _____
_____
_____

What Treatment(s) Offer You The Most Relief, And How Long Do The Benefits Last?
_____
_____
_____

Have There Been Any Recommendations For Diagnostic Testing Or Treatment That You Have Not Received? If 'YES', What Was Recommended, And Who Recommended It?
_____
_____
_____

HISTORY OF OTHER INJURIES:

Have You Ever Experienced The Same Or Similar Symptoms/Problems ***BEFORE*** This Work Injury? ___ YES ___ NO If 'YES', Please Explain In Detail:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(History Of Other Injuries – continued)

Have You Ever Had A ***PRIOR,*** Work Injury(ies)? ___ YES ___ NO If 'YES', Please Explain:

Have You Ever Received a ***PRIOR,*** Workers' Compensation Disability Award? ___ YES ___ NO
If 'YES', Please Explain:

Have You Ever Served In The **Military**? ___ YES ___ NO If 'YES', Did You Receive A Medical Discharge? ___ YES ___ NO If 'YES', Please Explain Why:

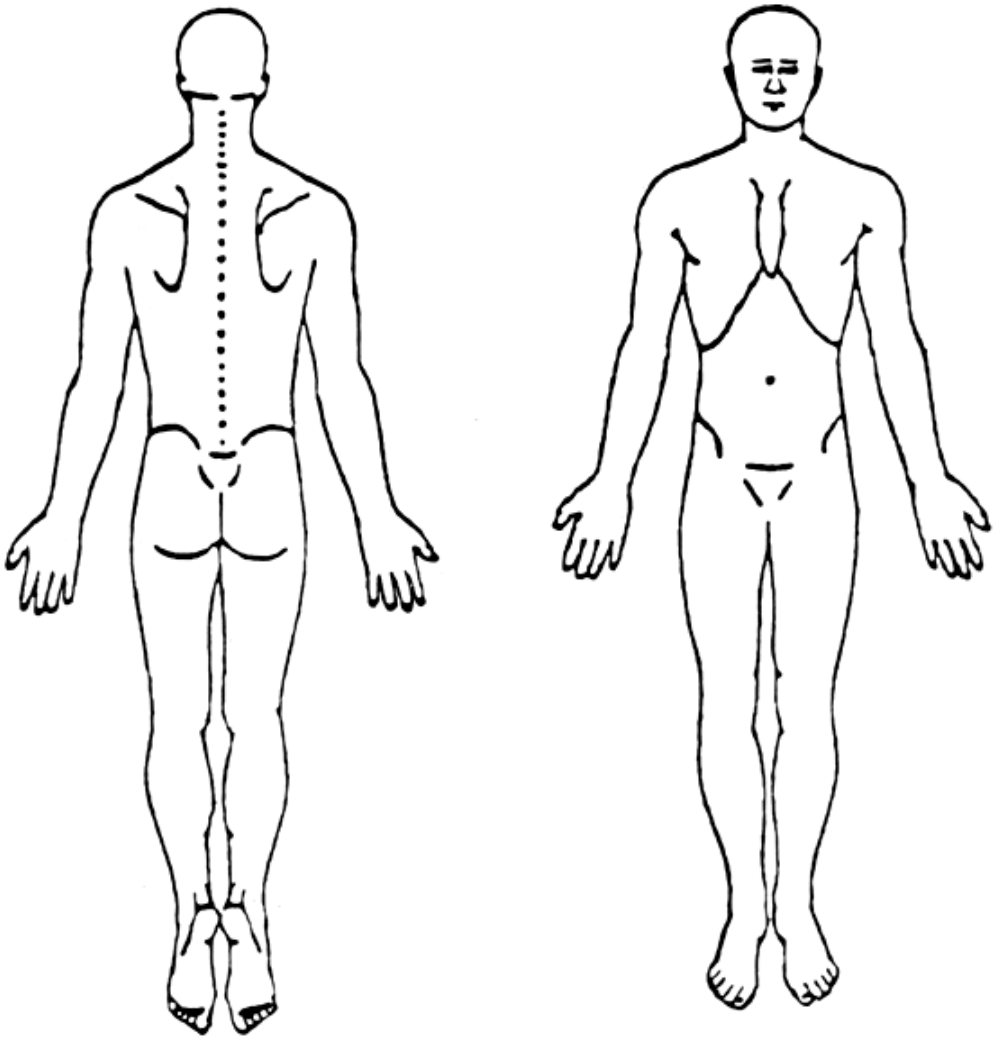
Have You Ever Had Any ***PRIOR, NON-WORK RELATED INJURIES?*** (e.g. Sprains/Strains, Slips/Falls, Motor Vehicle Accidents, Cumulative Or Repetitive Traumas, etc.) ___ YES ___ NO
If 'YES', Please Explain:

Have You Had Any ***NEW INJURIES*** Involving Body Parts Which Are A Part Of Your Current Work Injury? ___ YES ___ NO If 'YES', Please Explain:

CURRENT SYMPTOMS:

Mark The Areas On Your Body Where You Are Having Symptoms From Your **Work Injury**(ies).
Also, Review The Pain Scale On The Bottom Of This Page. The Doctor Will Be Asking You Questions.

P = Pain **N** = Numbness/Tingling **T** = Tenderness **B** = Burning **R** = Radiating



PAIN SCALE

0-1	=	**Minimal**	=	The pain is an annoyance but does not stop me from working.
2-3	=	**Slight**	=	I can tolerate the pain but it causes some difficulty in doing my work. However, it does not stop me from working.
5	=	**Moderate**	=	The pain causes a marked handicap in my ability to work, but I can continue.
7-8	=	**Moderate To Severe**	=	The pain is approaching the worst I have ever experienced or could imagine. It causes a significant problem with working and most of the time I can't.
10	=	**Severe**	=	The pain is the worst I have ever experienced or could imagine and causes me to stop all work and activity.

Please list your <u>current</u> symptoms/complaints resulting FROM YOUR WORK INJURY:

Complaint #1: _____
What Percentage Of The Time Do You Experience/Feel This Symptom? _____%
What Activities Make This Symptom Worse? _____
_____
What Makes This Symptom Better? _____
_____
Can/Do You Have This Symptom Without Activity? _____
Pain Scale _____ 0 - 10. The Doctor Will Discuss This With You.

Complaint #2: _____
What Percentage Of The Time Do You Experience/Feel This Symptom? _____%
What Activities Make This Symptom Worse? _____
_____
What Makes This Symptom Better? _____
_____
Can/Do You Have This Symptom Without Activity? _____
Pain Scale _____ 0 - 10. The Doctor Will Discuss This With You.

Complaint #3: _____
What Percentage Of The Time Do You Experience/Feel This Symptom? _____%
What Activities Make This Symptom Worse? _____
_____
What Makes This Symptom Better? _____
_____
Can/Do You Have This Symptom Without Activity? _____
Pain Scale _____ 0 - 10. The Doctor Will Discuss This With You.

Complaint #4: _____
What Percentage Of The Time Do You Experience/Feel This Symptom? _____%
What Activities Make This Symptom Worse? _____
_____
What Makes This Symptom Better? _____
_____
Can/Do You Have This Symptom Without Activity? _____
Pain Scale _____ 0 - 10. The Doctor Will Discuss This With You.

Complaint #5: _____
What Percentage Of The Time Do You Experience/Feel This Symptom? _____%
What Activities Make This Symptom Worse? _____
_____
What Makes This Symptom Better? _____
_____
Can/Do You Have This Symptom Without Activity? _____
Pain Scale _____ 0 - 10. The Doctor Will Discuss This With You.

(Current Symptoms - continued)

Is There A Time Of Day That You Feel Worse? ___ YES ___ NO If 'YES', Please Explain:
_____
_____
_____

In The Last **Two Months** Has Your Condition?___ Stayed The Same ___ Improved ___ Worsened
___ Fluctuated But Overall Has Stayed About The Same

If Your Condition Has **Worsened,** Please Explain: _____
_____
_____

If Your Condition **Continues To Improve,** Please Explain: _____
_____
_____

Do You Feel That Your Condition Will Improve With Time? ___ YES ___ NO Please Explain:
_____
_____
_____

Before This Work Injury, How Would You Describe Your Health? ___ Excellent ___ Good ___ Fair
Or ___ Poor If 'Fair' Or 'Poor', Please Explain: _____
_____
_____

JOB DESCRIPTION:

What Is Your Job Title? **(AT THE TIME OF YOUR INJURY)**: _____
Describe The Nature Of Your Work: _____
When Did You Start Working For This Employer? _____
How Many Hours Per Day Do You Normally Work? _____
What Hours Do You Normally Work? _____
How Many Days Per Week Do You Work? _____ How Many Days In A Row? _____
How Long Is Your Lunch Break? _____ How Long Are Your Rest Breaks? _____
How Many Rest Breaks Do You Get In A Normal Work Shift? _____
What Percent Of Your Work Day Do You Work Indoors? _____ % Outdoors? _____ %

At Work, How Many <u>Hours</u> Per Day Do You Do These Activities?

Leave Blank If It Doesn't Apply.

If Done Continuously, Circle.

___ Sit	___ Walk	___ Stand	___ Kneel
___ Squat	___ Climb	___ Bend	___ Twist
___ Reach	___ Crawl	___ Push	___ Pull
___ Keyboard	___ Type	___ Mouse	___ Write
___ Finger	___ Grasp		
___ Work Overhead			
___ Flex/Twist/Side-Bend/Extend Your Neck			

(Job Description – continued)

Please List Your Job Duties/Activities At Work: (WHEN YOU WERE INJURED)

A) _____
B) _____
C) _____
D) _____
E) _____
F) _____
G) _____

What Type Of Surface(s) Do You Work On? _____

Are You Required To **Lift At Work?** ___ YES ___ NO If 'YES', Please Answer The Following:

	Objects Lifted	Weight In Pounds	Times Per Day	Distance Carried/Feet
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____
3)	_____	_____	_____	_____
4)	_____	_____	_____	_____
5)	_____	_____	_____	_____

What Is the Heaviest Weight That You Are Required To Lift At Work? _____ Pounds
Do You Have To Bend Over Or Lean Forward While Lifting? ___ YES ___ NO

Are You Able To Lift The Same Amount Of Weight Now, As Before The Injury? ___ YES ___ NO
If 'NO', Please Explain What You Could Lift Before And What You Can Lift Now: _____
_____
_____

Does Your Job Require You To Reach Below, Above Or At Shoulder Level? ___ YES ___ NO
If 'YES', Please Explain: _____
_____
_____

Are You Required To Move Your Feet In A Repetitive Movement/Activity? ___ YES ___ NO
If 'YES', Please Describe: _____
_____
_____

Are You Required To Use Your Hands For Fine Manipulation, Grasping, Pushing, Pulling, Torquing?
___ YES ___ NO If 'YES', Please Describe: _____
_____
_____

(Job Description – continued)

Are You Exposed To Dust, Gas, Fumes, Vapors, Noise, Or Extreme Temperatures Or Humidity?
___ YES ___ NO If 'YES', Please Explain: _____
_____
_____

Are You Required To Work At Heights Or Walk On Uneven Ground? ___ YES ___ NO If 'YES', Please Describe: _____
_____
_____

Are You Required to Drive Vehicles Or Work Near Hazardous Equipment? ___ YES ___ NO
If 'YES', Please Describe: _____
_____
_____

Do You Have Any Special Seeing/Visual Or Hearing Requirements? ___ YES ___ NO If 'YES', Please Describe: _____
_____
_____

Are You Able To Perform Your Normal *Work Duties*? ___ YES ___ NO **If 'NO', Please Explain What Activities You Can't Do, Or Have Difficulty Performing:** _____
_____
_____
_____

WORK HISTORY:

Did You Have **More Than One Employer When You Were Injured?** ___ YES ___ NO
If 'YES', Please List The Employer(s), And The Activities Required At That Employment?
_____
_____
_____
_____
_____
_____

If 'YES', Did The Other Employment/Activities Listed Above **Contribute To, Or Further Worsen Your Condition?** ___ YES ___ NO If 'YES', Please Explain How? _____
_____
_____
_____
_____
_____

(Work History – continued)

Please List All Of **Your Previous Employers:** (i.e., Where You Have Worked Before The Job, Where Your Current Injury Occurred)

	Employer	Dates Of Employment	Job Title/Duties
A)	_____	_____	_____
B)	_____	_____	_____
C)	_____	_____	_____
D)	_____	_____	_____
E)	_____	_____	_____
F)	_____	_____	_____
G)	_____	_____	_____

Are You Still Working For The *Same Employer* Where Your Work Injury Occurred? ___ YES ___ NO
If 'NO', Answer The Questions Below. **If 'YES',** Skip The Following Questions And Go To The Next Section Entitled **'PAST MEDICAL HISTORY.'**

Why Aren't You Working For The Same Employer Now? _____
_____
_____
When Did You Stop Working For The Same Employer? _____

If You Are Not Working For The Same Employer As When You Were Injured, **Please List Your Employment Since Leaving:** ___ I Have Not Worked Since Leaving That Employment

	Employer	Dates Of Employment	Job Title/Duties
A)	_____	_____	_____
B)	_____	_____	_____
C)	_____	_____	_____
D)	_____	_____	_____
E)	_____	_____	_____
F)	_____	_____	_____
G)	_____	_____	_____

Who Is Your **Current Employer(s)**? _____
Are You Doing The Same Type Of Work? ___ YES ___ NO
If 'NO', Describe The Type Of Work You Are Doing Now, Including Details On Physical Activity:
_____
_____
_____
_____
_____
_____
_____
_____

(Work History - continued)

Has Any **NEW** Job Or Employment **Contributed To, Or Further Worsened Your Condition?**
___ YES ___ NO If 'YES', Please Name The Employer(s) And Explain How?

_____
_____
_____
_____
_____

Are You Going To Be **Retrained For Another Job/Occupation** As A Result Of This Work Injury?
___ YES ___ NO ___ I DO NOT KNOW ___ RECOMMENDED Please Describe:

_____
_____
_____

PAST MEDICAL HISTORY:

Please List **The Information About Your Medical History** In The Sections Below, With The **Approximate Dates**. If A Section Does Not Apply To You, Simply Mark An **(X)** In The 'Denied' Box:

Childhood Illnesses: ( ) Denied _____
_____

Childhood Injuries: ( ) Denied _____
_____

Allergies: ( ) Denied _____
_____

Present Medications Taken (Prescription & Over-The-Counter): ( ) Denied _____
_____

Surgeries: ( ) Denied _____
_____

Hospitalizations: ( ) Denied _____
_____

Adult Illnesses: ( ) Denied _____
_____
_____

Doctor(s) Seen Previous To Your Current Work Injury: Name & Location/City: ( ) Denied _____
_____
_____

FAMILY HISTORY:

List Any Health Problems In **Your Immediate Family**: (Mother, Father, Brother, Sister) ( ) Denied

_____
_____
_____

REVIEW OF SYSTEMS:

Please List Any Problems That You **Now Have** With The Following Body Systems:

Ears/Nose/Throat: ( ) Denied _____
Eyes: ( ) Denied _____
Lungs: ( ) Denied _____
Liver: ( ) Denied _____
G-I Tract (Stomach, Intestines, Bowels, Etc.): ( ) Denied _____
Kidney/Bladder: ( ) Denied _____
[Women] Reproductive System: ( ) Denied _____
Skin: ( ) Denied _____
Neurological: ( ) Denied _____
Heart/Circulation: ( ) Denied _____
Psychological: ( ) Denied _____

OFF WORK ACTIVITIES:

Do You Exercise? ___ YES ___ NO If 'YES', Please Describe Type & Frequency. If 'NO', Please Explain Why You Don't: _____
_____
Do You Participate In Any Sports Activities? ___ YES ___ NO If 'YES', Please Describe Type & Frequency: _____
_____
Do You Have Any Hobbies? ___ YES ___ NO If 'YES', Please Describe Type & Frequency:
_____
_____
Are You Able To Perform Your Normal/Regular Household Chores/Activities? ___ YES ___ NO
If 'NO', Please Explain What You Cannot Do & Why: _____
_____

SOCIAL HISTORY:

Are You? ( ) Married ( ) Single ( ) Separated ( ) Divorced ( ) Widowed
How Many Years Of Schooling Have You Had? _____
List Degrees, Diplomas, Licenses, Certifications You Hold: _____
Do You Use Alcohol? ___ YES ___ NO If 'YES', How Many Drinks Per Week? _____
Do You Use Tobacco? ___ YES ___ NO If 'YES', What Kind & Times Per Day Or Week?
_____
Do You Use Drugs? ___ YES ___ NO If 'YES', What Kind & How Many Times Per Day Or Week?
_____
List Any Other Habits, Describing Their Type & Frequency: _____
_____

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE!

Injured Worker's Signature: _____ Date: _____