WORKER'S COMP HISTORY

Name_____ Date of Birth: _____Email Address_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address_____ City_____State_____Zip_____

Name of wife/husband/significant other: _____

How did you hear about our office?: _____

Nearest relative not living with you: _____ Ph: _____

Emergency Contact: _____ Ph: _____

Name of Compensation Carrier:_____Phone (___)_____

Address of Carrier: _____City_____State_____Zip_____

NATURE OF ACCIDENT

Employer: _____Address:_____

Contact at employment for this accident (Personnel): _____ Ph: _____

1. Type of Business:_____ Your Occupation_____

2. Date Injured: _____ Hour _____AM/PM Last Date Worked: _____

3. Are you out of work? ( ) Yes ( ) No

4. Previous Workers' Compensation Injury? ( ) Yes ( ) No

5. Accident reported to employer? ( ) Yes ( ) No

Name of Person accident reported to _____

6. Injured at: _____City_____State_____Zip_____

7. Length of time worked there prior to accident: _____

8. Type of work being done at time of injury:_____

_____

9. In your own words, please describe accident:_____

_____

10. 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? _____

11. Are you: ( ) improved ( ) unchanged ( ) getting worse.

12. What types of medicines are you taking?_____

_____

Do these medicines help? ( ) Yes ( ) No ( ) Don't know

13. 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 _____

14. Prior to this accident, have you 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)?_____

_____

_____

15. Have you had any other serious accidents that required medical care? ( ) Yes ( ) No

If yes, please describe: _____

_____

16. Have you had any serious illnesses that required hospitalization? ( ) Yes ( ) No

Describe: _____

_____

_____

17. Have you had any surgeries? ( ) Yes ( ) No

If yes, list type of surgery and date: _____

_____

_____

18. Have you had any nervous or mental illnesses? ( ) Yes ( ) No

Have you had psychiatric care? ( ) Yes ( ) No

19. Have you received a medical discharge from the Armed Forces? ( ) Yes ( ) No

20. 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/Reg.	Duty Full-Time/Part-Time

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 of the time
4. My pain goes into my: ( ) right leg ( ) left leg ( ) both
5. I have tingling and /or numbness in my: ( ) right leg ( ) left leg ( ) both
6. My pain is worse when I:

a. Cough or sneeze ( ) Yes ( ) No

b. Sit ( ) Yes ( ) No

c. Bend ( ) Yes ( ) No

d. Walk ( ) Yes ( ) No

e. Lift ( ) Yes ( ) No

f. Push ( ) Yes ( ) No

g. Pull ( ) Yes ( ) No

7. My back is worse with sexual activity ( ) Yes ( ) No
8. My pain wakes me up during the night ( ) Yes ( ) No
9. Changes in the 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. My pain is worse when I:

a. Cough or sneeze ( ) Yes ( ) No

b. Bend forward ( ) Yes ( ) No

c. Lift ( ) Yes ( ) No

d. Push ( ) Yes ( ) No

e. Pull ( ) Yes ( ) No

f. 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 which 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:_____