WORK-COMP INJURY QUESTIONNAIRE

Name_____ **Date**_____

How did the accident occur? _____**Auto Collision** _____**On-the-job Injury** ____ **Other**
Date of accident_____**Time**_____(am/pm)**Location**_____
Did you report the injury to your Foreman, Employer or Auto Insurance company?_____Yes _____No
List the extent of the injuries you received as you know them_____
_____

CIRCLE THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

Headaches	Neck Pain	Sleeping Problems	Loss of Concentration
Chest Pain	Dizziness	Mid-Back Pain	Foggy Thoughts
Depression	Ears Ring	Low Back Pain	Sensitive to Motion
Jaw Pain or Click	Stomach Upset	Nervousness	Light Sensitivity
Pain Shoots Down Legs	Neck Stiffness	Fatigue	Pins and Needles in Legs
Pain Shoots Down Arms	Pins & Needles in Arms	Loss of Coordination	Other:_____
Blurry Vision			

Are you having trouble performing normal duties at work/school/home_____
_____
Were you taken, or did you go to the hospital after the accident?_____yes _____no
Name of hospital & location_____
Were you admitted? ___yes_____no **For how long?**_____
Emergency room only? _____yes _____no
Treatment received_____
Was any other doctor consulted after your accident? ___yes___no
If so, what was the doctor's name?_____ __DC __MD __DO ___DDS
What was the diagnosis?_____
_____
What treatment was given_____
_____
How often did you see the doctor?_____
Have you ever had any complaints in the involved area before?___yes___no
If so, what were the complaints?_____
_____
Before the injury, were you capable of working on an equal basis with others your age?___yes___no
Are your work activities restricted as a result of this accident?___yes____no
Have you lost any days of work? _____yes _____no
Dates_____
Insurance companies Involved_____
_____
Have you been contacted by an insurance adjuster or company representative regarding this claim?
__yes___no
Do you have an attorney that has advised you in this case?___yes ___no
Attorney's Name_____
Attorney's address_____
Attorney's phone #_____

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If on-the-job, did you complete an "Occupational Injury Report" form?__yes___no
Date Reported_____**Did you bring along your copy?**___yes___no.
If not, please obtain from your employer and provide this form to our office for processing your workman's compensation claim.
Do you have a claim number?___yes___no. **If yes, please provide**_____

Adjuster's name_____ **Employer at time of accident**_____

Employer's phone#_____**Employer's address**_____
_____

Workman's compensation insurance name & address if known_____
_____

LIFTING INJURIES

Weight of object _____lbs

Position of object lifted

_Above head level _At ground level _At head level _At shoulder level
_At waist level _Below waits level _Other:_____

Patients position while lifting

_Bending at the knees _Bending at the waist _Leaning forward
_Standing _Stretching on a ladder _Other:_____

Type of pain immediately after injury

_Achy _Burning _Dull _Gripping _Sharp
_Other:_____

FALLING INJURIES

Patient fell from where?

_Down the stairs _From 4 feet high _From 8 feet high
_From a ladder _From higher than 8 feet _Onto the ground
_Other:_____

Patient landed on?_____
_____

What body part of the patient was impacted first?_____
_____

Other body areas affected_____
_____

Describe additional details_____
_____

OTHER INJURIES

Immediately after injury, patient felt

_Achy pain _Burning pain _Dull pain _Numbness
_Sharp pain _Other:_____

OTHER INJURIES

Immediately after injury, patient felt

_Achy pain _Burning pain _Dull pain _Numbness
_Sharp pain _Other:_____

Where did you develop pain

_Left knee _Left shoulder _Lower back _Neck
_Right knee _Right shoulder _Other:_____

Other Injuries

_Twisted at the waist _Wrist injury from pulling _Wrist injury from pushing
_Wrist injury from repetitive use _Other:_____

Indicate areas of lacerations

_Left elbow _Left forearm _Left knee _Right elbow
_Right forearm _Right knee _Other:_____

AFTER ACCIDENT

Additional symptoms? _____

How much time after accident

_5 minutes _Immediately _One day _One hour
_Several days _Other:_____

Additional symptoms after accident

_Headaches _Lower back aches _Neck pain _Other:_____

Patient lost consciousness after injury? YES or NO
If YES for how long?_____
Patient received emergency care at scene? YES or NO
Where did you go immediately after accident

_Home _A walk-in emergency clinic
_To continued with scheduled plans _To the hospital emergency room
_To the hospital ER by ambulance _To work

Other comments_____
Describe additional details_____
_____

JOB DESCRIBTION

Regular activities

_Bending _Climbing _Crawling _Driving _Kneeling _Lifting
_Pulling _Pushing _Reaching _Running _Sitting _Squatting
_Standing _Walking _Other:_____

Hand/Wrist Movements

_Left hand firm grasping _Left hand light grasping _Right hand firm grasping
_Right hand light grasping _Typing _Other:_____

Weight normally lifted at work _____lbs

Time required for other work activities (hours)

Description *Duration*

_____

_____

Patient Signature_____ **Date**_____