Patient Information:

Name: ____ Age: _______ Date: _______________________
Address: (complete mailing address) ____
Phone No.: (____)______________ FAX:____________________ EMAIL: ________________________
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 if applicable)***

Name Of Business: ___________________________________ Phone No.: (____) ____________________
Address: ____

Insurance Carrier Information:

Name: ____ Phone No.: (____) ____________________
Address: ____
Claims Representative: ______________________________ Fax No.: (____) ______________________
Claim No.: ____

Information About Your 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 Injury Occurred: ____
____
____
____
____
____
____
____

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

(**History Of The Injury - continued)**

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

____

____

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

____

____

HISTORY OF TREATMENT:

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
'INITIALLY', Did You Go To A Hospital/Emergency Room? ___ YES ___ NO **If 'YES',**
Answer The Questions Below. **If 'NO',** 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 **ALL** Doctors You Have Seen Regarding Your Work Injury. Please List Them In Chronological Order/***The Order You Saw Them In:***

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: ______

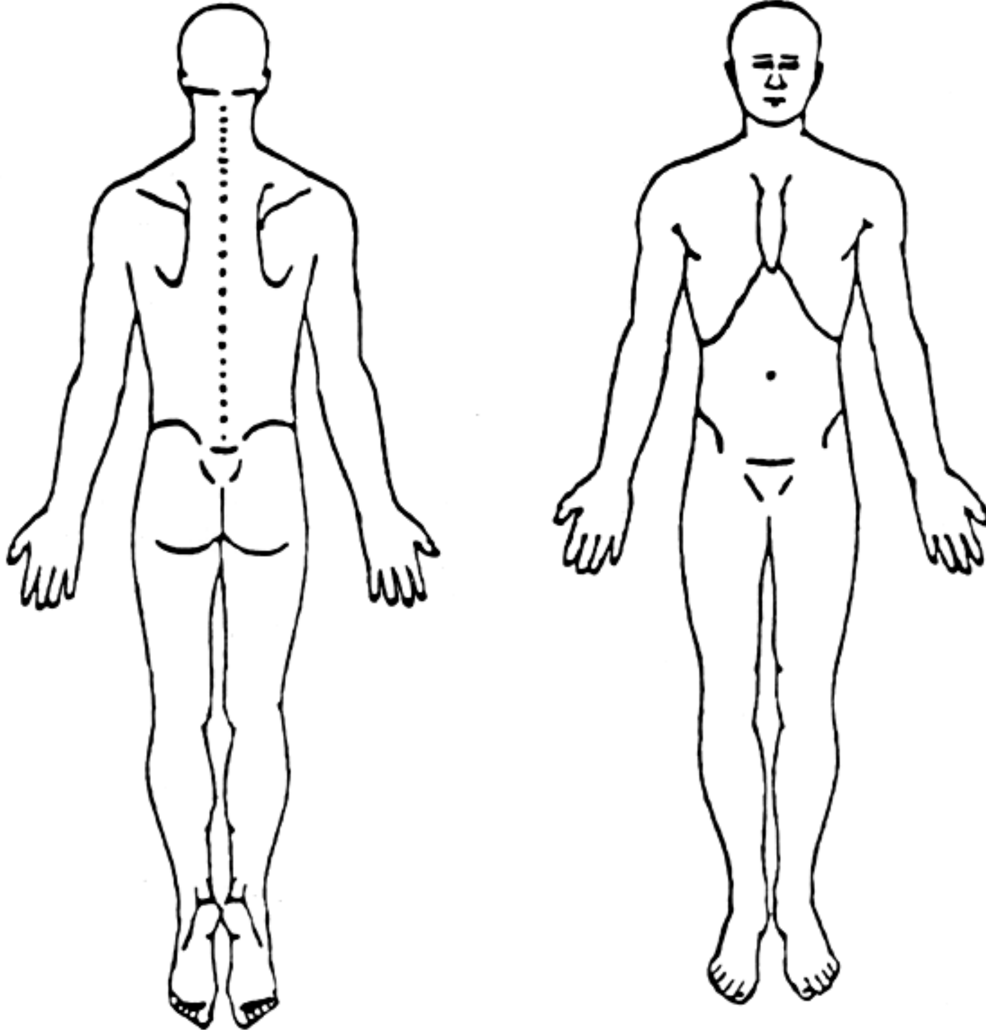
Have You Ever Had Any ***PRIOR, NON-WORK RELATED INJURIES?*** (e.g. Sprains/Strains, Slips/Falls, Motor Vehicle Accidents, Cumulative Or Repetitive Traumas, etc.) ___ YES ___ NO
If 'YES', Please Explain: ______

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 current 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
Who lives with you? ____________________ House or apartment? ___________ Number of stairs____
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!

FOR 2005 WORK INJURIES AND FORWARD

ROUTINE ACTIVITIES OF DAILY LIVING

Has your injury interfered with or cause problems for you in any of the following activities: (Circle all that apply)

1. Self-care, Teeth, Personal Hygiene.
2. Communication
3. Physical Activity
4. Sensory Function
5. Non-Specialized Hand Activities
6. Travel
7. Sexual Function
8. Sleep—how many hours before the injury did you sleep? How many hours do you sleep now?

Explain how the activities you circled are affected by your injury:

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

Injured Worker's Signature: ______________________________ Date: ____________________