WORK / COMP HISTORY

Patient _____ Home Phone ( )_____
Work #_____ Cell #_____
Address _____ City _____ St____ Zip_____
Age _____ Birth date _____ Sex ___F/___M. S.S# _____

Name of Compensation Carrier: _____ Phone ( ) _____-_____
Address of Carrier: _____ City _____, St____ Zip _____
Employer's Name: _____ Phone ( ) ____-_____
Employer's Address _____ City_____, St____ Zip_____

1.Type of business _____ Your Occupation _____

2.Date of injured _____ Hour _____ AM / PM Last date worked _____ Are you off work? ___**Y** /__**N**

3.Previous Workers' Compensation injury? ( ) Yes ( ) No

4.Accident reported to employer? ( ) Yes ( ) No
Name of person reported accident to: _____

5.Injured at: _____ City_____, St._____ Zip _____

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

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

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

9.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: _____

10. Are you: ( ) Improved ( ) Unchanged ( ) Getting Worse

11. What types of medicine(s) are you taking? _____
_____

12. Have you had physical therapy? ( ) Yes ( ) No If yes, how often? _____

13. 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, please describe: _____
_____

14. Have you had any other serious accidents which required medical care? ( ) Yes ( ) No
Describe:_____
_____

15. Have you had any serious illnesses that required hospitalization? ( ) Yes ( ) No
Describe:_____
_____
_____

16. Have you had any surgeries? ( ) Yes ( ) No
If yes, list type of surgery and date:_____
_____
_____

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

18. Have you had any 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/regular	Full time/part time
1.					
2.					
3.					
4.					

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/numbness	( ) right leg	( ) left leg	( ) both
6. My pain is worse when I:			
Cough or sneeze	( ) yes	( ) no	( ) sometimes
Sit	( ) yes	( ) no	( ) sometimes
Bend	( ) yes	( ) no	( ) sometimes
Walk	( ) yes	( ) no	( ) sometimes
Lift	( ) yes	( ) no	( ) sometimes
Push	( ) yes	( ) no	( ) sometimes
Pull	( ) yes	( ) no	( ) sometimes

7. My back pain is worse with sexual activity	( ) yes	( ) no	
8. My pain wakes me up during the night	( ) yes	( ) no	( ) sometimes
9. Changes in the weather affect my pain	( ) yes	( ) no	

Neck Pain:

1. My neck pain begin:	( ) 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/numbness	( ) right arm	( ) left arm	( ) both

5. My pain is worse when I:

Cough or sneeze	( ) yes	( ) no	( ) sometimes
Sit	( ) yes	( ) no	( ) sometimes
Bend forward	( ) yes	( ) no	( ) sometimes
Lift	( ) yes	( ) no	( ) sometimes
Push	( ) yes	( ) no	( ) sometimes
Pull	( ) yes	( ) no	( ) sometimes
Turn my head	( ) yes	( ) no	( ) sometimes

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 whish 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:

Bend/stoop:	( ) not at all	( ) occasionally	( ) frequently	( ) continuously
Squat:	( ) not at all	( ) occasionally	( ) frequently	( ) continuously
Crawl:	( ) not at all	( ) occasionally	( ) frequently	( ) continuously
Climb:	( ) not at all	( ) occasionally	( ) frequently	( ) continuously
Reach above shoulders:	( ) not at all	( ) occasionally	( ) frequently	( )continuously
Crouch:	( ) not at all	( ) occasionally	( ) frequently	( ) continuously
Kneel:	( ) not at all	( ) occasionally	( ) frequently	( ) continuously
Balancing:	( ) not at all	( ) occasionally	( ) frequently	( ) continuously
Pushing/Pulling: :	( ) not at all	( ) occasionally	( ) frequently	( )continuously

3. On the job, I lift:

Up to 10 pounds:	( ) not at all	( ) occasionally	( ) frequently	( )continuously
11-24 pounds:	( ) not at all	( ) occasionally	( ) frequently	( )continuously
25-34 pounds:	( ) not at all	( ) occasionally	( ) frequently	( ) continuously
35-50 pounds:	( ) not at all	( ) occasionally	( ) frequently	( ) continuously
51-74 pounds:	( ) not at all	( ) occasionally	( ) frequently	( ) continuously
75-100 pounds:	( ) not at all	( ) occasionally	( ) frequently	( ) continuously

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 required to drive automotive equipment? ( ) yes ( ) no
   Describe:_____
   _____

10. Are you exposed to marked changes in temperature and humidity? ( ) yes ( ) no
    Describe:_____
    _____

11. Are you exposed to dust, fumes and /or gases? ( ) yes ( ) no
    Describe:_____
    _____
    _____

12. Please list any additional comments:_____
_____
_____
_____

Signature:_____ Date:_____