

# WORK / COMP HISTORY

Patient \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ S/S # \_\_\_\_\_

Name of Compensation Carrier: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address of Carrier: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

1. Type of Business \_\_\_\_\_ Your Occupation \_\_\_\_\_

2. Date Injured \_\_\_\_\_ Hour \_\_\_\_\_ AM / PM Last Date Worked \_\_\_\_\_ Are you off work? ( ) Yes ( ) No

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

4. Accident reported to employer? ( ) Yes ( ) No Name of person reported accident to \_\_\_\_\_

5. Injured at: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ 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 by this doctor? \_\_\_\_\_

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

11. What types of medicines are you taking? \_\_\_\_\_

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

12. 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 \_\_\_\_\_

Does the physical therapy help? ( ) Yes ( ) No ( ) Don't know

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, describe: \_\_\_\_\_

Were these similar complaints the results of a previous accident(s)? ( ) Yes ( ) No

Please provide details of accident(s): \_\_\_\_\_

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

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

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

19. Have you returned to work since this accident? ( ) Yes ( ) No

If you have returned to work since you 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:

cough or sneeze ( ) Yes ( ) No

sit ( ) Yes ( ) No

bend ( ) Yes ( ) No

walk ( ) Yes ( ) No

lift ( ) Yes ( ) No

push ( ) Yes ( ) No

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 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:
  - Cough or sneeze                         Yes                     No
  - bend forward                             Yes                     No
  - lift                                          Yes                     No
  - push                                         Yes                     No
  - pull                                          Yes                     No
  - 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:  Yes                     No

**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 wish to make regarding your condition:

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**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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing / Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 you 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: \_\_\_\_\_