

WORK. COMP. HISTORY

PATIENT: _____ HM. PH.: (_____)

ADDRESS: _____ CITY: _____ ZIP: _____

AGE: _____ DOB: _____ SEX: _____ S.S.#: _____

NAME OF ADJUSTER: _____ PH: _____

W/C INS. CARRIER: _____ CLAIM #: _____

CARRIER ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

EMPLOYER INFO.: _____ PH: _____

EMPLOYER ADD.: _____ CITY: _____ ST: _____ ZIP: _____

1) Type of Business: _____ Your Occupation: _____

2) Date Injured: _____ Time: _____ AM / PM Last Day Worked: _____

3) Previous W/C Injury? Yes No

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

5) Injury location: _____ City: _____ St: _____
Zip: _____

6) Length of time worked there prior to accident? Days: _____ Hours: _____

7) Type of work being done at time of injury? _____

8) In your own words, describe accident: _____

9) Have you been treated by another doctor for this accident? Yes No

If Yes, please list all doctors' names/address/phone number: _____

What type of treatment did you receive? _____

How long were you treated by these doctor/s? _____

10) Are you: Improved () Unchanged () Don't Know ()

11) What types of medications are you taking? _____

Do these medicines help? Yes No Don't know

- | | | | |
|---|-----------|----------|------|
| 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 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: | | | |
| Cough or Sneeze | Yes | No | |
| Sit | Yes | No | |
| Bend | Yes | No | |
| Walk | Yes | No | |
| Lift | Yes | No | |
| Push | Yes | No | |
| Pull | 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 wish to make regarding your condition:

JOB DESCRIPTION:

(In terms of an 8-hour workday, "occasionally" means 33%; "frequently" means 34%; "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:

Crouch:

Kneel:

Balancing:

Pushing / Pulling:

Reach above
shoulder level:

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

