WORK / COMP HISTORY

Pati	ent			Phone ()						
Add	ress	City		State	Zip .						
Age	Birthdate	Sex	S/S# _								
	ne of Compensation Carrier:										
	iress of Carrier:										
	ployer's Name:										
	ployer's Address:										
	Type of Business										
1.	Date Injured Hour AM / PM Last	Your Occ	Jupation	Are you off work?	() Ye	 .s () No				
	Previous Workers' Compensation Injury? () Yes (•	•	Ť					
	Accident reported to employer? () Yes () No Na		eported accide	ent to							
	Injured at:										
	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:		··· ···				····				
											
			O								
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 ()										
	What types of medicines are you taking?			·							
• • • •											
	Do these medicines help? () Yes () No () Do	n't know									
12.	Have you had physical therapy? () Yes () No		ften?								
	() 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 ph	nysical complai	nts similar to	what you have nov	w?						
	()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):										
		_									
											

Describe:	Describe:												
If. 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 your accident, please fill out the information below: DATE	5. Have	. Have you had any serious illnesses that required hospitalization? () Yes () No											
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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 walk () Yes () No walk () Yes () No lift () Yes () No push () 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													
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ECK PAIN:							
. My neck pain began:	() gra	adually	() suddenly		
. I have pain:	() so	metimes	() all of the ti	ime	•
. My pain goes into my:	() rig	ht arm	() left arm	() both
. I have tingling and/or numbness in my:	() rig	jht arm	.() left arm	() both
. My pain is worse when i:							
cough or sneeze	() Y€	es	() No		
bend forward	() Ye	95	() No		
lift	() Ye	es	() No		
push	() Ye	98	. () No		
pull	() Ye	es	() No		
turn my head	() Ye	es	() No		
. My pain wakes me up during the night	() Ye	98	() No		,
. Changes in the weather affect my pain	() Ye	es	() No		
. I have neck stiffness	() Ye	es	() No		
. I have headaches	() Ye	es	() No		•
. If I do get headaches, they occur:	() sc	metimes	; () all of the t	ime	e
							
		J	OB DES	CRI	PTION:		
(In terms of an 8-hour workday, "occasion	onal	ly" n্	neans 33°	%, "	frequently" m	ear	ns 34% to 66%, and "continuously" me
67% to 100% of the day).					•		
I. In a typical 8-hour workday, I: (Circle #	of h	ours	/ activity	y)			Min
Sit: 1 2 3 4 5		6	7 8		hours		
Stand: 1 2 3 4 5	5	6	7 8		hours		
Walk: 1 2 3 4 5	5	6	7 8		hours		
2. On the job, I perform the following acti	ivitie	es:					
NOT AT ALL			SIONALL	Y	FREQUENT	LY	CONTINUOUSLY
Bend / stoop ()	~`		()	-	()		()
Squat ()			()		()		()
Crawl ()		•	()		()		()
Climb () Reach above			()		()		()
shoulder level ()			()		()		()
Crouch ()			()		()		()
Kneel ()			()		()		()
Balancing ()			()		()		()
Pushing / Pulling ()			()		()		()

; ;	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 () () ()
	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
	Do you use your hands for repetitive actions, such as: SIMPLE GRASPING FIRM GRASPING FINE MANIPULATING Right hand () Yes () No () Yes () No Left hand () Yes () No () Yes () No
	Left Hallo
	Are you required to work on unprotected heights? () Yes () No Describe:
	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: