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 your 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 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
   - 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: ( ) 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% 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	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Reach above shoulder level	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Balancing	( )	( )	( )	( )
Pushing / Pulling	( )	( )	( )	( )

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 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 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: _____