

# WORKER'S COMPENSATION INJURY QUESTIONNAIRE

**Please Print:**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Employer's Business Name at time of Accident: \_\_\_\_\_

Employer's Phone: \_\_\_\_\_ Employer's Address \_\_\_\_\_

Occupation: \_\_\_\_\_

Yes  No Previous Worker's Compensation Injury? Impairment Rating: \_\_\_\_\_

Length of time at this job prior to injury: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time of injury: \_\_\_\_\_ Last Date Worked: \_\_\_\_\_

Please explain what you were doing at the time you were injured and how the accident happened (lifting, bending, walking, carrying standing, etc.) \_\_\_\_\_

When did the pain begin?(please be specific) \_\_\_\_\_

Where did you first feel it?(please be specific) \_\_\_\_\_

Was the pain intense at first or did it gradually worsen? \_\_\_\_\_

**REPORT ACCIDENT/ACCIDENT OBSERVER**

What date did you report this injury on? \_\_\_\_\_

Who did you report this injury to? \_\_\_\_\_ Position? \_\_\_\_\_

Did anyone else observe accident/injury?  Yes  No If yes, Name: \_\_\_\_\_  
Position: \_\_\_\_\_

**SYMPTOMS FROM ACCIDENT**

Did you experience bleeding cuts or bruises?  Yes  No  
If bleeding cuts where? \_\_\_\_\_ If bruises, where? \_\_\_\_\_

Please describe how you felt. PLEASE BE SPECIFIC.

Immediately after the accident: \_\_\_\_\_

Later that  Day  Night: \_\_\_\_\_

The next day(s): \_\_\_\_\_

**Check symptoms that have become apparent since the accident/injury:**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Nervousness             | <input type="checkbox"/> Loss of balance       | <input type="checkbox"/> Sleeping trouble | <input type="checkbox"/> Headache           |
| <input type="checkbox"/> Neck Pain/Stiffness     | <input type="checkbox"/> Loss of smell         | <input type="checkbox"/> Toe Numbness     | <input type="checkbox"/> Fainting           |
| <input type="checkbox"/> Midback Pain            | <input type="checkbox"/> Loss of taste         | <input type="checkbox"/> Finger Numbness  | <input type="checkbox"/> Anxiety            |
| <input type="checkbox"/> Low Back Pain           | <input type="checkbox"/> Loss of memory        | <input type="checkbox"/> Cold Hands       | <input type="checkbox"/> Seizures           |
| <input type="checkbox"/> Eyes sensitive to light | <input type="checkbox"/> Pins & Needles - Arms | <input type="checkbox"/> Cold Feet        | <input type="checkbox"/> Visual disturbance |
| <input type="checkbox"/> Pain behind eyes        | <input type="checkbox"/> Pins & Needles - Legs | <input type="checkbox"/> Chest Pain       | <input type="checkbox"/> Forgetfulness      |
| <input type="checkbox"/> Dizziness               | <input type="checkbox"/> Shortness of breath   | <input type="checkbox"/> Constipation     | <input type="checkbox"/> Blurred Vision     |
| <input type="checkbox"/> Cold sweats             | <input type="checkbox"/> Head seems too heavy  | <input type="checkbox"/> Diarrhea         | <input type="checkbox"/> Double Vision      |
| <input type="checkbox"/> Face flushed            | <input type="checkbox"/> Irritability          | <input type="checkbox"/> Fatigue          | <input type="checkbox"/> Confused           |
| <input type="checkbox"/> Ringing/Buzzing Ears    | <input type="checkbox"/> Depression            | <input type="checkbox"/> Tension          | <input type="checkbox"/> Disoriented        |
| <input type="checkbox"/> Fever                   | <input type="checkbox"/> Other _____           |   |   |

**MECHANISM OF INJURY:**

Please explain the mechanism of the injury (*only fill in those sections that apply to you*):

**FALL:**

Yes  No Did you hit anything when you fell? If yes, what? \_\_\_\_\_

Yes  No Were you carrying anything when you fell? If yes, what? \_\_\_\_\_  
How much did it weigh? \_\_\_\_\_ lbs.

Yes  No Did you twist when you fell? If so, to which side?  Left  Right

Yes  No Was the area lighted?

Describe the condition of the area (slippery, graveled, etc.) \_\_\_\_\_

What part of the body did you fall on? \_\_\_\_\_

How far did you fall? (In feet) \_\_\_\_\_

What did you land on? \_\_\_\_\_

**LIFT/PULL:**

How much did the object weigh? \_\_\_\_\_ lbs.

- Yes No Did you fall after the injury? If yes, how far? \_\_\_\_\_  
Yes No Did you hit anything when you fell? If yes, what? \_\_\_\_\_  
Yes No Were you twisting when you were lifting/pulling? If yes, to which side? Left Right

How far off the ground did you have the object before the pain started? \_\_\_\_\_  
Yes No Did you drop the object when the pain started?  
Yes No Did it land on you? Where? \_\_\_\_\_  
 Did you lift with your Legs Back Other \_\_\_\_\_

**BEND:**

- Yes No Were you lifting when you were bent over? If yes, how much did the object weigh? \_\_\_\_\_ lbs.  
 How far were you bent over? \_\_\_\_\_  
Yes No Did you fall when the pain started? How far? \_\_\_\_\_  
Yes No Were you twisting when you bent forward? Toward which side? Left Right  
Yes No Did you land on anything? If so, what? \_\_\_\_\_

**WORK STATUS HISTORY:**

- Yes No Have you lost time from work as a result of this new injury? If yes, please give dates: \_\_\_\_  
Yes No Have you gone back to work? When: \_\_\_\_\_  
 If yes, status or work: Modified Regular  
 List restrictions you have been placed on: \_\_\_\_\_  
 If you have gone back to work, list activities that are:  
 PAINFUL: \_\_\_\_\_  
 DIFFICULT: \_\_\_\_\_  
Yes No If you are currently on disability (time loss), do you want to go back to work doing your \_\_\_\_\_ regular job? If no, why not? \_\_\_\_\_  
Yes No Are there any problems you have with a fellow employee, supervisor, or manager that needs to be discussed? If yes, please explain: \_\_\_\_\_

**FIRST DOCTOR/HOSPITAL/CLINIC:**

- Yes No Were you hospitalized as a result of this accident? If yes, where: \_\_\_\_\_  
 Doctor 1 Name: \_\_\_\_\_ Date of First Visit: \_\_\_\_\_  
Yes No Were you examined? Yes No Were X-rays taken?  
 What diagnosis did the doctor give you? \_\_\_\_\_  
Yes No Were you given treatment? If yes, what type? \_\_\_\_\_  
 What benefits did you receive from this treatment? \_\_\_\_\_  
 Date of last treatment? \_\_\_\_\_  
Yes No Did the doctor refer you to another health professional? If yes, to whom and for what? \_\_\_\_  
Yes No Did you follow the doctor's recommendation? If no, why not? \_\_\_\_\_

**SECOND DOCTOR/CLINIC:**

- Doctor 2 Name: \_\_\_\_\_ Date of First Visit: \_\_\_\_\_  
Yes No Were you examined? Yes No Were X-rays taken?  
 What diagnosis did the doctor give you? \_\_\_\_\_  
Yes No Were you given treatment? If yes, what type? \_\_\_\_\_  
 What benefits did you receive from this treatment? \_\_\_\_\_  
 Date of last treatment? \_\_\_\_\_

**PRIOR SIMILAR SYMPTOMS:**

- Yes No Did you have any physical complaints just before the accident? If yes, please describe in detail: \_\_\_\_\_  
Yes No Have you ever had any prior injuries, accidents, diseases or treatment to the area of your \_\_\_\_\_ body now affected?  
 If yes, what part was previously injured? \_\_\_\_\_ Date previously injured? \_\_\_\_\_  
 Describe previous injury: \_\_\_\_\_  
Yes No Were you treated? By whom? \_\_\_\_\_  
 Date treatment began: \_\_\_\_\_ Date treatment ended: \_\_\_\_\_  
 The last date you felt pain or problems from that previous injury: \_\_\_\_\_

PLEASE SEE PAGE 4 FOR JOB DESCRIPTION

### JOB DESCRIPTION

In terms of an 8 - hour workday: **Occasionally** = 33%, **Frequently** = 34% to 66%, **Continuously** = 67% to 100%

In a typical 8 - hour workday, I (circle the number of hours of 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

On the job, I perform the following activities:

	Not at all	Occasional	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 Level	<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"/>
Pulling/Pushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

On the job, I lift:

	Not at all	Occasionally	Frequently	Continuously
Up to 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 to 24 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25 to 34 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35 to 50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 to 74 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75 to 100 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Yes  No Are you required to bend over while doing any lifting?  
 Yes  No Are your feet used in repetitive movements, such as operating foot controls?

Do you use your hands for repetitive actions such as:

	Simple Grasping	Firm Grasping	Find Manipulating
Right Hand	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Left Hand	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

- Yes  No Are you required to work at unprotected heights? If yes, please describe: \_\_\_\_\_  
 Yes  No Are you required to be around moving machinery? If yes, please describe: \_\_\_\_\_  
 Yes  No Are you exposed to marked changes in temperature and humidity? If yes, please describe: \_\_\_\_\_  
 Yes  No Are you required to drive automotive equipment? If yes, please describe: \_\_\_\_\_  
 Yes  No Are you exposed to dust, flames, and/or gases? If yes, please describe: \_\_\_\_\_

Please list any additional comments: \_\_\_\_\_  
 \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_