WORK / COMP HISTORY

Name____ Phone (   ) ____________________

Address____ City _____________________ State _____ Zip _____

Age_______ Date of Birth _________________   M / F

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 Worker's 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 complains 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 accident(s) which required medical care? ( ) Yes ( ) No

Describe: ____

15. Have you had any serious illnesses that require hospitalization? ( ) Yes ( ) No

Describe: ____

____

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16. Have you had any surgeries? ( ) Yes ( ) No

If yes, list type of surgery and date: ____

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17. Have you had any nervous of 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 complains 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	( )	( )	( )	( )
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 ever 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 automobile 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:____________________