WORK / COMP HISTORY

Date _____

Patient _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ SSA# _____ - _____ - _____

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. Are you off work _____ Last date worked _____

3. Previous Workers' Compensation Injury? _____ Yes _____ No

4. Accident reported to employer? _____ Name of person accident reported to _____

Injured at (Address) _____ City _____ State _____ Zip _____

6. Length of time worked for employer prior to accident _____

7. Type of work being done at time of injury _____

8. Describe in your own words, what happened at the time of the accident _____

_____

_____

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

If yes, give doctor's name & 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 medicine(s) are you taking? _____

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 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 _____ If yes, describe _____

_____

Were these complaints the results of a previous accident(s)? Yes _____ No _____

If yes, please give details of the accident(s), including dates _____

_____

_____

WORK / COMP HISTORY (CONTINUED)

14. Have you had any other serious accidents which required medical care? _____ Yes _____ No

Describe (Includes dates) _____

_____

15. Have you had any serious illnesses that required hospitalization? _____ Yes _____ No

Describe (Includes dates) _____

_____

_____

16. Have you had any surgeries? _____ Yes _____ No

If yes, list type of surgery (Includes dates) _____

_____

_____

17. Have you had any nervous or mental illnesses? _____ Yes _____ No
Have you had any psychiatric care? ___ Yes _____ No

If yes, list type of care (Includes dates) _____

18. Have you received a medical discharge from the Armed Forces? _____ Yes _____ No

19. Have you returned to work since your accident? _____ Yes _____ No
If you have returned to work since your accident , please fill out the employment information below:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY	REGULAR 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 during the night _____ Yes _____ No
9. Changes in the weather affect my pain _____ Yes _____ No

WORK / COMP HISTORY (CONTINUED)

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 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 the number of hours performing each 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:

Bend / Stoop	_____ Never	_____ Occasionally	_____ Frequently	_____ Continuously
Squat	_____ Never	_____ Occasionally	_____ Frequently	_____ Continuously
Crawl	_____ Never	_____ Occasionally	_____ Frequently	_____ Continuously
Climb	_____ Never	_____ Occasionally	_____ Frequently	_____ Continuously
Reach above shoulder level	_____ Never	_____ Occasionally	_____ Frequently	_____ Continuously
Crouch	_____ Never	_____ Occasionally	_____ Frequently	_____ Continuously
Kneel	_____ Never	_____ Occasionally	_____ Frequently	_____ Continuously
Balancing	_____ Never	_____ Occasionally	_____ Frequently	_____ Continuously
Pushing / Pulling	_____ Never	_____ Occasionally	_____ Frequently	_____ Continuously

WORK / COMP HISTORY (CONTINUED)

3. On the job I lift

Up to 10 pounds	Never _____	Occasionally _____	Frequently _____	Continuously _____
11 to 24 pounds	Never _____	Occasionally _____	Frequently _____	Continuously _____
25 to 34 pounds	Never _____	Occasionally _____	Frequently _____	Continuously _____
35 to 50 pounds	Never _____	Occasionally _____	Frequently _____	Continuously _____
51 to 74 pounds	Never _____	Occasionally _____	Frequently _____	Continuously _____
75 to 100 pounds	Never _____	Occasionally _____	Frequently _____	Continuously _____

4. Do you have to bend over while doing any lifting? Yes _____ No _____

5. Are your feet used for repetitive movements, such as operating foot controls? Yes _____ No _____

6. Do you use your hands for repetitive movements, such as:

	Simple Grasping	Firm Grasping	Fine Manipulation
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. Additional Comments:

_____

_____

Patient Signature _____ Date _____