

# 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 illness 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 | REG. DUTY<br>LIGHT DUTY | FULL-TIME<br>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**

- 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:

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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               | <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"/> |
| Pushing / Pulling          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

|                        |                          |                          |                          |                          |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 3. 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"/> |

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 | <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 |

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: \_\_\_\_\_