WORKERS' COMPENSATION INJURY QUESTIONNAIRE

Please Print:

Name_____ Today's Date_____

Employer's Business Name at time of Accident:

_____

Employer's Phone:_____

Employer's Address:_____

City_____State_____Zip_____

Occupation:_____

Previous Workers' Compensation Injury? ❑ YES ❑ NO

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? (be specific)_____

Where did you first feel the pain? (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? ❑ NO ❑ YES

If bleeding, where:_____

If bruises, where:_____

Please describe how you felt. BE SPECIFIC

Immediately after the accident:_____

Later that day:_____

The next day(s):_____

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

❑ Neck Pain/Stiffness	❑ Mid-Back Pain/Stiffness	❑ Low Back Pain/Stiffness
❑ Headache	❑ Chest Pain	❑ Sciatic Pain/Pain down legs
❑ Nervousness	❑ Loss of Balance	❑ Sleeping Trouble
❑ Loss of Smell	❑ Dizziness	❑ Toe numbness
❑ Loss of Taste	❑ Cold Hands	❑ Pins and Needles - Hands
❑ Loss of Memory	❑ Cold Feet	❑ Pins and Needles - Legs
❑ Fainting	❑ Anxiety	❑ Seizures
❑ Pain behind Eye(s)	❑ Cold Sweats	❑ Face Flushed
❑ Ringing/Buzzing in Ears	❑ Fever	❑ Shortness of Breath
❑ Heavy Head	❑ Irritability	❑ Depression
❑ Constipation	❑ Diarrhea	❑ Fatigue
❑ Tension	❑ Blurred Vision	❑ Double Vision
❑ Confusion	❑ Disorientation	❑ Other_____

MECHANISM OF INJURY:

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

FALL:

Did you hit anything when you fell? ❑ YES ❑ NO

If yes, what?_____

Were you carrying anything when you fell? ❑ YES ❑ NO

If yes, what?_____

How much did it weigh? _____lbs.

Did you twist when you fell? ❑ YES ❑ NO

If so, which side? ❑ LEFT ❑ RIGHT

Was the area lighted? ❑ YES ❑ NO

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

_____

What part of the body did you fall on?_____

LIFT/PULL:

How much did the object weigh? _____lbs.

Did you fall after the injury? ❑ YES ❑ NO

If yes, how?_____

Did you hit anything when you fell? ❑ YES ❑ No

If yes, what?_____

Were you twisting what you were lifting/pulling? ❑ YES ❑ NO

If so, to which side? ❑ LEFT ❑ RIGHT

How far off the ground did you have the object before the pain started?_____ft._____in.

Did you drop the object when the pain started? ❑ YES ❑ NO

If so, did it land on you? ❑ YES ❑ NO

If it landed on you, where?_____

Did you lift with your: ❑ LEGS ❑ BACK ❑ OTHER_____

BEND:

Were you lifting when you were bent over? ❑ YES ❑ NO

If yes, how much did the object weigh?_____lbs.

How far were you bent over?_____degree angle.

Did you fall when the pain started? ❑ YES ❑ NO

If yes, how far?_____

Were you twisting when you bent forward? ❑ YES ❑ NO

If so, to which side? ❑ LEFT ❑ RIGHT

Did you land on anything? ❑ YES ❑ NO

If so, what?_____

WORK STATUS HISTORY:

Have you lost time from work as a result of this new injury? ❑ YES ❑ NO

If yes, please give dates:_____

Have you gone back to work? ❑ YES ❑ NO

If yes, status of work: ❑ Modified ❑ Regular

If modified, list restrictions you have been placed on:_____

_____

If you've gone back to work, list activities that are painful or difficult:_____

_____

If you are currently on disability, (time loss) do you want to go back to work doing your regular job?

❑ YES ❑ NO

If no, why?_____

Are there any problems you have with a fellow employee, supervisor, or manager that needs to be discussed? ❑ YES ❑ NO

If yes, please explain:_____

_____

_____

FIRST DOCTOR/HOSPITAL/CLINIC:

Were you hospitalized as a result of this accident? ❑ YES ❑ NO

If yes, where?_____

Doctor #1 Name_____ Date_____

Were you examined? ❑ YES ❑ NO

Were X-Rays taken? ❑ YES ❑ NO

What diagnosis did the Doctor give you?_____

_____

Were you given any treatment? ❑ YES ❑ NO

If yes, what type?_____

What benefits did you receive from this treatment?_____

_____

Date of last treatment:_____

Did the Doctor refer you to another health professional? ❑ YES ❑ NO

If yes, to whom?_____

For what reasons?_____

Did you follow the Doctor's recommendation? ❑ YES ❑ NO

If no, why not?_____

_____

SECOND DOCTOR/CLINIC:

Doctor #2 Name_____ Date_____

Were you examined? ❑ YES ❑ NO

Were X-Rays taken? ❑ YES ❑ NO

What diagnosis did the Doctor give you?_____

_____

Were you given any treatment? ❑ YES ❑ NO

If yes, what type?_____

What benefits did you receive from this treatment?_____

_____

Date of last treatment:_____

PRIOR SIMILAR SYMPTOMS:

Did you have any physical complaints just before the accident? ❑ YES ❑ NO

If yes, please describe in detail:_____

_____

_____

Have you ever had any prior injuries, accidents, diseases or treatment to the area of your body now affected? ❑ YES ❑ NO

If yes, what part(s)?_____

Date previously injured?_____

Were you treated? ❑ YES ❑ NO

If yes, by whom?_____

Date treatment began:_____ Date treatment ended:_____

The last date you felt pain or problems from that previous injury?_____

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	Occasionally	Frequently	Constantly
Bend/Stoop	❑	❑	❑	❑
Squat	❑	❑	❑	❑
Crawl	❑	❑	❑	❑
Climb	❑	❑	❑	❑
Reach Above Head	❑	❑	❑	❑
Crouch	❑	❑	❑	❑
Kneel	❑	❑	❑	❑
Balancing	❑	❑	❑	❑
Pulling/Pushing	❑	❑	❑	❑

On the job, I lift:

Up to 10 pounds	❑	❑	❑	❑
11 to 24 pounds	❑	❑	❑	❑
25 to 34 pounds	❑	❑	❑	❑
35 to 50 pounds	❑	❑	❑	❑
51 to 74 pounds	❑	❑	❑	❑
75 to 100 pounds	❑	❑	❑	❑
Over 100 pounds	❑	❑	❑	❑

Are you required to bend over while doing any lifting? ❑ YES ❑ NO

Are your feet used in repetitive movements, such as operating foot controls? ❑ YES ❑ NO

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

Are you required to work at unprotected heights? ❑ YES ❑ NO

If yes, please describe:_____

Are you required to be around moving machinery? ❑ YES ❑ NO

If yes, please describe:_____

Are you exposed to marked changes in temperature and humidity? ❑ YES ❑ NO

If yes, please describe:_____

Are you required to drive automotive equipment? ❑ YES ❑ NO

If yes, please describe:_____

Are you exposed to dust, flames, and/or gases? ❑ YES ❑ NO

If yes, please describe:_____

Please list any additional comments:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature_____ Date_____