

WORK/COMP HISTORY

Patient \_\_\_\_\_  
Telephone \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip \_\_\_\_\_  
Age \_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_ SSN \_\_\_\_\_  
Name of Compensation Carrier \_\_\_\_\_  
Telephone \_\_\_\_\_  
Address of Carrier \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip \_\_\_\_\_  
Employer's Name \_\_\_\_\_  
Telephone \_\_\_\_\_  
Address of Employer \_\_\_\_\_  
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: \_\_\_\_\_  
\_\_\_\_\_
  10. Are you: ( ) improved ( ) unchanged ( ) getting worse
  11. What types of medications are you taking? \_\_\_\_\_  
\_\_\_\_\_
- Do these medications 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 \_\_\_\_\_

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 there 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 illnesses 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	Light/Reg. Duty	Full/Part Time

**CURRENT MEDICAL COMPLAINTS**

**BACK PAIN:**

- Currently, I have pain in my: ( ) low back ( ) mid back ( ) upper back
- My pain began: ( ) gradually ( ) suddenly
- I have pain: ( ) sometimes ( ) all of the time
- My pain goes into my: ( ) right leg ( ) left leg ( ) both
- I have tingling and/or Numbness in my: ( ) right leg ( ) left leg ( ) both

6. My pain is worse when I:
- |                 |                              |                             |
|-----------------|------------------------------|-----------------------------|
| Cough or sneeze | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sit             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bend            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Walk            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lift            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Push            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pull            | <input type="checkbox"/> Yes | <input type="checkbox"/> 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 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bend forward    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lift            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Push            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pull            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Turn my head    | <input type="checkbox"/> Yes | <input type="checkbox"/> 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 a 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 10lbs.	( )	( )	( )	( )
11 to 24lbs.	( )	( )	( )	( )
12 to 34lbs.	( )	( )	( )	( )
35 to 50 lbs.	( )	( )	( )	( )
51 to 74 lbs.	( )	( )	( )	( )
75 to 100 lbs.	( )	( )	( )	( )

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: \_\_\_\_\_