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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?Y/N
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
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

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	LIGHTDUTY/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/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 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 # 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 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 automotive equipment? ( )Yes ( )No

Describe: _____

_____

_____

11. Are you exposed to dust, fumes and/or gases? ( )Yes ( )No

Describe: _____

_____

_____

12. Please list any additional comments: _____

_____

_____

By signing below, I certify that all the statements above are true and accurate.

Signature:_____ Date:_____/_____/_____