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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:_____/_____/_______