

WORK/COMP HISTORY

Name _____ Date of Accident: _____

1. Name of employer at time of accident: _____

2. Length of time worked there prior to accident: _____

3. Type of work being done at time of injury: _____

4. In your own words, please describe accident: _____

5. 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? _____

6. Are you: Improved Unchanged Getting Worse

7. What type of medicines are you taking? _____

Do these medicines help? Yes No Don't know

8. 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

9. 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): _____

10. Have you had any other serious accidents which required medical care? Yes No

Describe: _____

11. Have you had any serious illnesses that required hospitalization? () Yes () No

Describe: _____

12. Have you had any surgeries? () Yes () No

If yes, list type of surgery and date: _____

13. Have you had any nervous or mental illnesses? () Yes () No

Have you had psychiatric care? () Yes () No

14. Have you received a medical discharge from the Armed Forces? () Yes () No

15. 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 DUTY 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 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 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

NECK PAIN (continued):

- 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 MANIPULATION
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: _____

DATE

PATIENT'S SIGNATURE

WORKER'S COMP ADDITIONAL INFO SHEET

PLEASE ANSWER COMPLETELY THE FOLLOWING QUESTIONS:

Employee Information

1. Name as it appears on employment record/or established Worker's Compensation claim:

2. Complete home address (Number, Street, City, County, Zip):

3. Marital Status (circle one): Married Single Divorced Widowed

4. Social Security Number: _____

5a. Current Age: _____

5b. Birth Date: Month _____ Day _____ Year _____

6. Have you ever filed a previous application for this injury? () Yes () No

7. Have you ever received your wages during this disability? () Yes () No

8. Have you filed other claims with the Bureau or Industrial Commission? () Yes () No

If yes, give claim numbers & parts of body for those claims: _____

9. Have you applied to your employer for payment? () Yes () No

If yes, what action has been taken: _____

10. Have your medical expenses been paid by your employer? () Yes () No

Employer Information

1. Give name and complete mailing address of employer: _____

2. County of employment and employer's phone number: _____

3. Date and time accident happened: _____

4. Date and time you reported the accident to your employer: _____

5. Name and title of person you reported the accident to: _____

6. Last day you worked: _____

7. Date you returned to work (If still off, answer OFF): _____

8. How long have you worked for your present employer? _____

If less than 12 months, please list the names of all previous employers going back 12 months (Please give complete name and address for all employers):

a. _____

b. _____

c. _____

9. Do you have an attorney? () Yes () No

Attorney's Name: _____

Attorney's Address: _____

Attorney's Phone: _____

10. Witnesses to Accident:

a. Name: _____

Address: _____

b. Name: _____

Address: _____

DATE

PATIENT'S SIGNATURE