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Workers Compensation History

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Name: _____ Sex: _____ Date Of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: ( ) _____ Cell: ( ) _____ Marital Status: _____

Social Security #: _____ E-mail Address: _____

Referred to this office by: Friend _____ Dr. _____ Other _____

Name of Compensation Carrier: _____ Phone: ( ) _____

Address: _____ City: _____ State: _____ Zip: _____

Case Manager: _____ Phone: ( ) _____

Workers Compensation Board Number: _____

Carrier Case Number: _____

At the time of injury……

Employer: _____ Type of Business: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Employer Phone: ( ) _____

Date Injured: _____ Time: _____ ○ AM ○ PM

Are you still employed where the injury occurred? ○ YES ○ NO

Are you off Work? ○ YES ○ NO If YES, last date worked: _____

Job Title _____ **Work Activities** _____

Was Accident Reported to employer? ○ YES ○ NO

Name of person reported accident to: _____

Injured at: _____ City: _____ State: _____ Zip: _____

Length of time worked there prior to accident: _____

In your own words, please describe accident: _____

_____

Are you currently receiving workers compensation? ○ YES ○ NO
Have you received a prior workers compensation award? ○ YES ○ NO

Have you had any *prior* work injuries? ○ YES ○ NO

Describe *previous accident*: _____

Describe *previous injuries*: _____

Is there any residual pain from the previous injury? ○ YES ○ NO
How much better did you feel prior to your current condition? (example 100%, 80% etc.)_____

CURRENT WORK STATUS……

Are you currently employed? ☐ Full Time ☐ Part Time
☐ Retired ☐ Unemployed since: _____

Current Employer: _____ **Current Occupation:** _____

How long have you been at your current job?

○ <1 month	○ 4-7 months	○ 1-3 years	○ 8-12 years
○ 1-3 months	○ 8-12 months	○ 3-7 years	○ 13+ years

What best describes your type of work:

○ **Sedentary Duty**- Occasional lifting/carrying small items (10 lbs max); occasional walking and standing

○ **Light Duty**- Frequent lifting (20 lbs max) and carrying objects (10 lbs max); significant walking/standing with sitting, pushing, and pulling

○ **Medium Duty**- Lifting (50 lbs max) with frequent lifting/carrying of objects (25 lbs max)

○ **Heavy Duty**- Lifting (100 lbs max) with frequent lifting/carrying of objects (50 lbs max)

○ **Very Heavy duty**- Lifting objects (heavier than 100 lbs max) with frequent lifting/carrying of objects (heavier than 50 lbs max)

Your present job involves:

Sitting:	**Standing:**	**Walking:**	**Lifting:**	**Driving:**
○ < 1 hour	○ < 1 hour	○ < 1 hour	○ < 5 lbs	○ < 1 hour
○ 1-3 hours	○ 1-3 hours	○ 1-3 hours	○ 5-20 lbs	○ 1-3 hours
○ 4-7 hours	○ 4-7 hours	○ 4-7 hours	○ 20-40 lbs	○ 4-7 hours
○ 8-11 hours	○ 8-11 hours	○ 8-11 hours	○ 40-60 lbs	○ 8-11 hours
○ +12 hours	○ +12 hours	○ +12 hours	○ +60 lbs	○ +12 hours

Typing:	**Mouse use:**	**Grasping:**	**Crawling:**	**Climbing:**
○ < 1 hour	○ < 1 hour	○ < 1 hour	○ < 1 hour	○ < 1 hour
○ 1-3 hours	○ 1-3 hours	○ 1-3 hours	○ 1-3 hours	○ 1-3 hours
○ 4-7 hours	○ 4-7 hours	○ 4-7 hours	○ 4-7 hours	○ 4-7 hours
○ 8-11 hours	○ 8-11 hours	○ 8-11 hours	○ 8-11 hours	○ 8-11 hours
○ +12 hours	○ +12 hours	○ +12 hours	○ +12 hours	○ +12 hours

☐ Fine manipulation, pushing or pulling with hands ☐ Repetitive motion

Are you experiencing any limitations of working due to your injury?

- ☐ Cannot turn neck
- ☐ Cannot bend neck
- ☐ Cannot turn back
- ☐ Cannot bend back
- ☐ Cannot use left arm
- ☐ Cannot use right arm
- ☐ Cannot use left leg
- ☐ Cannot use right leg
- ☐ Pain limits amount of movement
- ☐ Cannot use knee due to pain
- ☐ Cannot drive due to pain
- ☐ Cannot stand due to pain
- ☐ Cannot sit due to pain
- ☐ Cannot walk due to pain
- ☐ Increased fatigability
- ☐ Unable to lift more than 10 lbs
- ☐ Unable to lift more than 15-20 lbs
- ☐ Unable to lift more than 20-50 lbs
- ☐ Unable to lift more than 50 lbs
- ☐ Inability to carry out usual working duties without pain or discomfort
- ☐ Inability to carry out activities of daily living without pain or discomfort

How many rest breaks do you receive?

☐ No breaks ☐ A lunch break only ☐ A lunch break and 1 rest break ☐ A lunch break and 2 rest breaks ☐ A lunch break and 3 rest breaks ☐ A lunch break and 4 or more rest breaks

What type of surface do you work on?

☐ Asphalt ☐ Gravel ☐ Carpet ☐ Wood ☐ Hard floors
☐ Grass ☐ Dirt ☐ Mud ☐ Pavement (in door

Are you exposed to:

☐ Dust ☐ Fumes ☐ Chemicals ☐ Extreme heat ☐ High Humidity
☐ Gas ☐ Vapors ☐ Loud noise ☐ Extreme cold

Are you required to:

☐ Work at heights ☐ Drive vehicles ☐ Walk on uneven ground ☐ Work near hazardous equipment

Are you pressured for speed, performance, perfection?

☐ Constantly ☐ Frequently ☐ Often ☐ Occasionally ☐ Almost never

% of day outdoors:

○ 100 ○ 90 ○ 80 ○ 70 ○ 60 ○ 50 ○ 40 ○ 30 ○ 20 ○ 10 ○ 0

Have you ever been fired or laid-off? ☐ Fired ☐ Laid-off ☐ Both fired and laid-off

POST INJURY……

Immediately following the injury, how did you feel?

☐ Shaken Upset ☐ Nervous ☐ Confused ☐ Frightened ☐ Dazed ☐ Distressed
☐ Light headed ☐ Dizzy ☐ Weak ☐ Disoriented ☐ Nauseous ☐ Other _____

Where did pain occur? _____

Did you lose consciousness? ○ Yes ○ No ○ Unsure **If yes, how long?** _____

What type of emergency treatment did you receive?

☐ Bandaging ☐ Bracing ☐ CPR ☐ A neck collar ☐ Splinting ☐ Other_____

Immediate destination after injury:_____

Who drove you there?_____ **Where were cuts located?**_____

Were you admitted to the hospital? ○ Yes ○ No **If yes, How long?** _____

When did you go to the hospital? ☐ At time of accident ☐ Next day

How did you get to hospital? ☐ Ambulance ☐ Police car ☐ Private Transportation

Name of Hospital: _____ Attended by Dr._____

Were any of the following radiological tests performed? If yes, what part of the body?

X-ray: _____ MRI: _____ CAT Scan: _____

Treatment administered: _____

Recommendations: _____

Medications Prescribed: _____

Have you had multiple visits to one facility for this injury? ○ Yes ○ No **How many?** _____

Have you had multiple visits to several facilities for this injury? ○ Yes ○ No **How many?** _____

Circumstances: ☐ Aggravation or re-injury ☐ Lack of progress/Healing

☐ Continued pain ☐ New injury affecting this complaint

List any other doctors you have seen for this condition:

Dr. _____ Specialty: _____ Initial visit date: _____

Treatment Administered: _____

Dr. _____ Specialty: _____ Initial visit date: _____

Treatment Administered: _____

Dr. _____ Specialty: _____ Initial visit date: _____

Treatment Administered: _____

Please list all medications you are currently taking with condition:

Medication:	Condition:

Chief Complaints and Symptoms……

Neck pain—Select areas that the pain runs into from the neck

☐ None	☐ Head	☐ Upper back pain		
☐ Left shoulder	☐ Left arm	☐ Left forearm	☐ Left wrist	☐ Left hand
☐ Right shoulder	☐ Right arm	☐ Right forearm	☐ Right wrist	☐ Right hand

Back pain—Select areas that pain runs into from back

☐ None	☐ Low Back	☐ Mid Back	☐ Upper Back	☐ Buttocks
☐ Left buttocks	☐ Left Hip	☐ Left thigh	☐ Left Knee	☐ Left foot
☐ Right Buttocks	☐ Right thigh	☐ Right Hip	☐ Right Knee	☐ Right foot

Other Symptoms:

☐ Headaches	☐ Pain in hands or Arms	☐ Chest pains
☐ Neck Pain	☐ Numbness in hands or arms	☐ Heart attack
☐ Sleeping Problems	☐ Pain in legs or feet	☐ High blood pressure
☐ Low Back Pain	☐ Tension	☐ Nervousness
☐ Irritability	☐ Lights bother eyes	☐ Depression
☐ Loss of Memory	☐ Pain between shoulders	☐ Dizziness
☐ Neck Stiff	☐ Sinus	☐ Shoulder pain
☐ Shortness of Breath	☐ Fever	☐ Joint swelling
☐ Loss of Balance	☐ Allergies	☐ Asthma
☐ Jaw clenching	☐ Nightmares	☐ Difficulty sleeping at night
☐ Excessive irritability	☐ A loss of concentration	☐ Fatigue
☐ Grinding of teeth at night	☐ Fear of driving in a car	☐ Anxiety
☐ Ringing in ears	☐ Blurry Vision	☐ Jaw pain

My pain is worse when I:

☐ Cough or sneeze	☐ Sit	☐ Bend	☐ Walk	☐ Lift	☐ Push
☐ Pull	☐ with sexual activity		☐ Sleep/wakes me up during the night		

Additional symptoms/complaints: _____

_____

_____

Signature of patient or Legal Guardian: _____ **Date:** _____