

**WORKERS' COMPENSATION PATIENT QUESTIONNAIRE**

Dear Patient/Injured Worker:

It is important in a workers' compensation case to establish a complete and accurate base of personal and historical information. This information often becomes a critical part of the decision making process in coming to final determinations or conclusions about your case. Therefore, **your help and cooperation in answering this questionnaire as completely and accurately as possible is necessary and appreciated.** This is very important to the people involved in handling your case and for you to receive appropriate and fair compensation.

Please, review and complete this patient questionnaire. Doing this, will significantly reduce your time in the office. **THE AMOUNT OF TIME, WHICH HAS BEEN SCHEDULED FOR YOUR APPOINTMENT, DOES TAKE INTO CONSIDERATION THAT THIS HAS BEEN DONE.** Thank you very much!

**IF YOU NEED ADDITIONAL SPACE TO WRITE, PLEASE USE THE BACK OF THE PAGES.**

**PHYSICIAN USE ONLY:**

Evaluation Date: \_\_\_\_\_  
Evaluation Began: \_\_\_\_\_ A.M. \_\_\_\_\_ P.M. \_\_\_\_\_  
Evaluation Ended: \_\_\_\_\_ A.M. \_\_\_\_\_ P.M. \_\_\_\_\_

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**Employee Information:**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: (complete mailing address) \_\_\_\_\_  
Phone No.: (\_\_\_\_) \_\_\_\_\_ Date Of Birth: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_  
\_\_ Male \_\_ Female \* \_\_ Right Handed \_\_ Left Handed \_\_ Both \* Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Employer Information: (Your Employer At The Time You Were Injured)**

Name Of Business: \_\_\_\_\_ Phone No.: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_

**Workers' Compensation Insurance Carrier Information:**

Name: \_\_\_\_\_ Phone No.: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_  
Claims Representative: \_\_\_\_\_ Fax No.: (\_\_\_\_) \_\_\_\_\_  
Claim No.: \_\_\_\_\_

**Information About Your Work Injury:**

Date Of Injury: \_\_\_\_\_ Time The Injury Occurred: \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.  
Date You Reported Your Injury To Your Employer/Supervisor: \_\_\_\_\_  
Name Of Person You Reported Your Injury To: \_\_\_\_\_  
Where Did Your Injury Occur? (Address Or Description Of Location): \_\_\_\_\_  
\_\_\_\_\_

**Attorney Information: ( ) Check If None**

Name: \_\_\_\_\_ Phone No.: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_  
Fax No.: (\_\_\_\_) \_\_\_\_\_

**HISTORY OF THE INJURY:**

Please Describe How Your Work Injury Occurred: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please List The Injured Body Parts, As A Result Of Your Work Injury:**

\_\_\_\_\_

How Did Your Symptoms Come On? \_\_ Suddenly \_\_ Gradually **If 'Gradually', Over What**  
Period of Time? \_\_\_\_\_

When Did You Realize/Know That You Were Injured? Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Type Of Doctor (degree or specialty): \_\_\_\_\_ Number Of Treatments/Visits? \_\_\_\_\_  
Describe Treatment And/Or Tests: \_\_\_\_\_  
What Did This Doctor Say Was Wrong With You? \_\_\_\_\_  
Date When Treatment Started: \_\_\_\_\_ Date When Treatment Stopped: \_\_\_\_\_  
What Was The Result/Outcome Of The Treatment? \_\_\_\_\_  
Still Treating With This Doctor? \_\_\_ YES \_\_\_ NO If 'YES', How Often? \_\_\_\_\_  
Did This Doctor Take You Off Work? \_\_\_ YES \_\_\_ NO If 'YES', Give Dates: \_\_\_\_\_  
Did This Doctor Restrict Or Modify Your Work Activities? \_\_\_ YES \_\_\_ NO If 'YES', How? \_\_\_\_\_  
Did This Doctor Refer You Anywhere Else? \_\_\_ YES \_\_\_ NO If 'YES', Where And Why? \_\_\_\_\_

**Name Of Doctor/Facility #4:** \_\_\_\_\_ City/Location: \_\_\_\_\_  
Type Of Doctor (degree or specialty): \_\_\_\_\_ Number Of Treatments/Visits? \_\_\_\_\_  
Describe Treatment And/Or Tests: \_\_\_\_\_  
What Did This Doctor Say Was Wrong With You? \_\_\_\_\_  
Date When Treatment Started: \_\_\_\_\_ Date When Treatment Stopped: \_\_\_\_\_  
What Was The Result/Outcome Of The Treatment? \_\_\_\_\_  
Still Treating With This Doctor? \_\_\_ YES \_\_\_ NO If 'YES', How Often? \_\_\_\_\_  
Did This Doctor Take You Off Work? \_\_\_ YES \_\_\_ NO If 'YES', Give Dates: \_\_\_\_\_  
Did This Doctor Restrict Or Modify Your Work Activities? \_\_\_ YES \_\_\_ NO If 'YES', How? \_\_\_\_\_  
Did This Doctor Refer You Anywhere Else? \_\_\_ YES \_\_\_ NO If 'YES', Where And Why? \_\_\_\_\_

**Name Of Doctor/Facility #5:** \_\_\_\_\_ City/Location: \_\_\_\_\_  
Type Of Doctor (degree or specialty): \_\_\_\_\_ Number Of Treatments/Visits? \_\_\_\_\_  
Describe Treatment And/Or Tests: \_\_\_\_\_  
What Did This Doctor Say Was Wrong With You? \_\_\_\_\_  
Date When Treatment Started: \_\_\_\_\_ Date When Treatment Stopped: \_\_\_\_\_  
What Was The Result/Outcome Of The Treatment? \_\_\_\_\_  
Still Treating With This Doctor? \_\_\_ YES \_\_\_ NO If 'YES', How Often? \_\_\_\_\_  
Did This Doctor Take You Off Work? \_\_\_ YES \_\_\_ NO If 'YES', Give Dates: \_\_\_\_\_  
Did This Doctor Restrict Or Modify Your Work Activities? \_\_\_ YES \_\_\_ NO If 'YES', How? \_\_\_\_\_  
Did This Doctor Refer You Anywhere Else? \_\_\_ YES \_\_\_ NO If 'YES', Where And Why? \_\_\_\_\_

Were Any Other Tests, Examinations, Treatments, or Therapy Done That Were Not Described Above? \_\_\_ YES \_\_\_ NO If 'YES', Please Describe What Was Done And What The Result Was: (use the back of this page if necessary): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do You Treat Yourself? \_\_\_ YES \_\_\_ NO If 'YES', Please Explain How: \_\_\_\_\_  
\_\_\_\_\_

**(History Of Treatment – continued)**

Are You Currently Taking Medication To Relieve The Effects Of This Injury? \_\_\_ YES \_\_\_ NO  
If 'YES', Please Describe What You Take, (Prescription or Non-Prescription), How Much It Helps,  
How Often You Take It, Etc.: \_\_\_\_\_  
\_\_\_\_\_

Are You Currently Using A Brace, Support, Cane, Crutch(es), Wheelchair, TENS Unit, Or Other  
Aid Because Of The Effects Of This Injury? \_\_\_ YES \_\_\_ NO If 'YES', Please Describe Type  
And How Often It Is Used: \_\_\_\_\_  
\_\_\_\_\_

What Treatment(s) Offer You The Most Relief, And How Long Do The Benefits Last?  
\_\_\_\_\_  
\_\_\_\_\_

Have There Been Any Recommendations For Diagnostic Testing Or Treatment That You Have Not  
Received? If 'YES', What Was Recommended, And Who Recommended It?  
\_\_\_\_\_  
\_\_\_\_\_

**HISTORY OF OTHER INJURIES:**

Have You Ever Experienced The Same Or Similar Symptoms/Problems **BEFORE** This Work Injury?  
\_\_\_ YES \_\_\_ NO If 'YES', Please Explain In Detail:  
\_\_\_\_\_  
\_\_\_\_\_

Have You Ever Had A **PRIOR**, Work Injury(ies)? \_\_\_ YES \_\_\_ NO If 'YES', Please Explain:  
\_\_\_\_\_  
\_\_\_\_\_

Have You Ever Received a **PRIOR**, Workers' Compensation Disability Award? \_\_\_ YES \_\_\_ NO  
If 'YES', Please Explain: \_\_\_\_\_  
\_\_\_\_\_

Have You Ever Served In The **Military**? \_\_\_ YES \_\_\_ NO If 'YES', Did You Receive A Medical  
Discharge? \_\_\_ YES \_\_\_ NO If 'YES', Please Explain Why: \_\_\_\_\_  
\_\_\_\_\_

Have You Ever Had Any **PRIOR, NON-WORK RELATED INJURIES?** (e.g. Sprains/Strains,  
Slips/Falls, Motor Vehicle Accidents, Cumulative Or Repetitive Traumas, etc.) \_\_\_ YES \_\_\_ NO  
If 'YES', Please Explain: \_\_\_\_\_  
\_\_\_\_\_

Have You Had Any **NEW INJURIES** Since Your Current Work Injury Occurred? \_\_\_ YES \_\_\_ NO  
If 'YES', Please Explain: \_\_\_\_\_  
\_\_\_\_\_

**ACTIVITIES OF DAILY LIVING/CURRENT COMPLAINTS:**

- 1. Self-Care, Personal Hygiene: (**Example** – *Urinating, Defecating, Brushing Teeth, Combing Hair, Bathing, Dressing Oneself, Eating*)
- 2. Communication: (**Example** – *Writing, Typing, Seeing, Hearing, Speaking*)
- 3. Physical Activity: (**Example** – *Standing, Sitting, Reclining, Walking, Climbing Stairs*)
- 4. Sensory Function: (**Example** – *Hearing, Seeing, Tactile Feeling, Tasting, Smelling*)
- 5. Nonspecialized Hand Activities: (**Example** – *Grasping, Lifting, Tactile Discrimination*)
- 6. Travel: (**Example** – *Riding, Driving, Flying*)
- 7. Sexual Function: (**Example** – *Orgasm, Ejaculation, Lubrication, Erection*)
- 8. Sleep: (**Example** – *Restful, Nocturnal Sleep Pattern*)

Please Indicate Below, Limitations Or Difficulties You Have With Any Of The Above Activities.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_

**Please list your current symptoms/complaints resulting FROM YOUR WORK INJURY:**

**Complaint #1:** \_\_\_\_\_  
\_\_\_\_ % Of Time Felt? 0-10 Pain Scale \_\_\_\_\_? Symptoms Without Activity? \_\_\_ YES \_\_\_ NO  
What Activities Make This Symptom Worse? \_\_\_\_\_  
What Makes This Symptom Better? \_\_\_\_\_

**Complaint #2:** \_\_\_\_\_  
\_\_\_\_ % Of Time Felt? 0-10 Pain Scale \_\_\_\_\_? Symptoms Without Activity? \_\_\_ YES \_\_\_ NO  
What Activities Make This Symptom Worse? \_\_\_\_\_  
What Makes This Symptom Better? \_\_\_\_\_

**Complaint #3:** \_\_\_\_\_  
\_\_\_\_ % Of Time Felt? 0-10 Pain Scale \_\_\_\_\_? Symptoms Without Activity? \_\_\_ YES \_\_\_ NO  
What Activities Make This Symptom Worse? \_\_\_\_\_  
What Makes This Symptom Better? \_\_\_\_\_

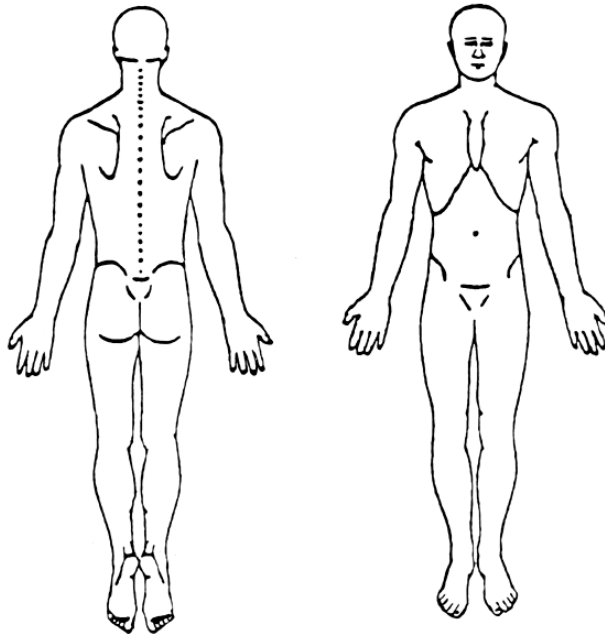
**Complaint #4:** \_\_\_\_\_  
\_\_\_\_ % Of Time Felt? 0-10 Pain Scale \_\_\_\_\_? Symptoms Without Activity? \_\_\_ YES \_\_\_ NO  
What Activities Make This Symptom Worse? \_\_\_\_\_  
What Makes This Symptom Better? \_\_\_\_\_

**Complaint #5:** \_\_\_\_\_  
\_\_\_\_ % Of Time Felt? 0-10 Pain Scale \_\_\_\_\_? Symptoms Without Activity? \_\_\_ YES \_\_\_ NO  
What Activities Make This Symptom Worse? \_\_\_\_\_  
What Makes This Symptom Better? \_\_\_\_\_

**PLEASE USE BACK OF PAGE IF NEEDED**

Mark The Areas On Your Body Where You Are Having Symptoms From Your **Work Injury(ies)**.

**P** = Pain    **N** = Numbness/Tingling    **T** = Tenderness    **B** = Burning    **R** = Radiating



In The Last **Two Months** Has Your Condition? \_\_\_ Stayed The Same    \_\_\_ Improved    \_\_\_ Worsened  
\_\_\_ Fluctuated But Overall Has Stayed About The Same

If Your Condition Has **Worsened**, Please Explain: \_\_\_\_\_  
\_\_\_\_\_

If Your Condition **Continues To Improve**, Please Explain: \_\_\_\_\_  
\_\_\_\_\_

Do You Feel That Your Condition Will Improve With Time? \_\_\_ YES    \_\_\_ NO    Please Explain:  
\_\_\_\_\_  
\_\_\_\_\_

Before This Work Injury, How Would You Describe Your Health? \_\_\_ Excellent    \_\_\_ Good    \_\_\_ Fair  
Or \_\_\_ Poor    If 'Fair' Or 'Poor', Please Explain: \_\_\_\_\_

**JOB DESCRIPTION:**

What Is Your Job Title? (**AT THE TIME OF YOUR INJURY**): \_\_\_\_\_

Describe The Nature Of Your Work: \_\_\_\_\_

When Did You Start Working For This Employer? \_\_\_\_\_

How Many Hours Per Day Do You Normally Work? \_\_\_\_\_

What Hours Do You Normally Work? \_\_\_\_\_

How Many Days Per Week Do You Work? \_\_\_\_\_    How Many Days In A Row? \_\_\_\_\_

How Long Is Your Lunch Break? \_\_\_\_\_    How Long Are Your Rest Breaks? \_\_\_\_\_

How Many Rest Breaks Do You Get In A Normal Work Shift? \_\_\_\_\_

What Percent Of Your Work Day Do You Work Indoors? \_\_\_\_\_ %    Outdoors? \_\_\_\_\_ %

*At Work, How Many Hours Per*    \_\_\_ Sit    \_\_\_ Walk    \_\_\_ Stand    \_\_\_ Kneel

**Day Do You Do These Activities?**    \_\_\_ Squat                    \_\_\_ Climb                    \_\_\_ Bend                    \_\_\_ Twist  
    \_\_\_ Reach                    \_\_\_ Crawl                    \_\_\_ Push                    \_\_\_ Pull  
    \_\_\_ Keyboard                \_\_\_ Type                    \_\_\_ Mouse                    \_\_\_ Write  
**Leave Blank If It Doesn't Apply.**    \_\_\_ Finger                    \_\_\_ Grasp  
    \_\_\_ Work Overhead  
**If Done Continuously, Circle.**    \_\_\_ Flex/Twist/Side-Bend/Extend Your Neck

**Please List Your Job Duties/Activities At Work: (WHEN YOU WERE INJURED)**

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What Type Of Surface(s) Do You Work On? \_\_\_\_\_

	<u>Objects Lifted</u>	<u>Weight In Pounds</u>	<u>Times Per Day</u>	<u>Distance Carried/Feet</u>
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____
3)	_____	_____	_____	_____
4)	_____	_____	_____	_____

Do You Have To Bend Over Or Lean Forward While Lifting? \_\_\_ YES \_\_\_ NO

Are You Able To Lift The Same Amount Of Weight Now, As Before The Injury? \_\_\_ YES \_\_\_ NO

**If 'NO', Please Explain What You Could Lift Before And What You Can Lift Now:** \_\_\_\_\_

Does Your Job Require You To Reach Below, Above Or At Shoulder Level? \_\_\_ YES \_\_\_ NO

If 'YES', Please Explain: \_\_\_\_\_

Are You Required To Move Your Feet In A Repetitive Movement/Activity? \_\_\_ YES \_\_\_ NO

If 'YES', Please Describe: \_\_\_\_\_

Are You Required To Use Your Hands For Fine Manipulation, Grasping, Pushing, Pulling, Torquing?

\_\_\_ YES \_\_\_ NO If 'YES', Please Describe: \_\_\_\_\_

Are You Exposed To Dust, Gas, Fumes, Vapors, Noise, Or Extreme Temperatures Or Humidity?

\_\_\_ YES \_\_\_ NO If 'YES', Please Explain: \_\_\_\_\_

Are You Required To Work At Heights Or Walk On Uneven Ground? \_\_\_ YES \_\_\_ NO If 'YES',

Please Describe: \_\_\_\_\_

Are You Required to Drive Vehicles Or Work Near Hazardous Equipment? \_\_\_ YES \_\_\_ NO

If 'YES', Please Describe: \_\_\_\_\_

Do You Have Any Special Seeing/Visual Or Hearing Requirements? \_\_\_ YES \_\_\_ NO If 'YES',

Please Describe: \_\_\_\_\_

Are You Able To Perform Your Normal *Work Duties*? \_\_\_ YES \_\_\_ NO **If 'NO', Please Explain**

**What Activities You Can't Do, Or Have Difficulty Performing:** \_\_\_\_\_

**WORK HISTORY:**



Did You Have **More Than One Employer When You Were Injured?** \_\_\_ YES \_\_\_ NO  
If 'YES', Please List The Employer(s), And The Activities Required At That Employment?

If 'YES', Did The Other Employment/Activities Listed Above **Contribute To, Or Further Worsen Your Condition?** \_\_\_ YES \_\_\_ NO If 'YES', Please Explain How? \_\_\_\_\_

Please List All Of **Your Previous Employers:** (i.e., Before Your Current Work Injury Occurred)

	<u>Employer</u>	<u>Dates Of Employment</u>	<u>Job Title/Duties</u>
A)	_____	_____	_____
B)	_____	_____	_____
C)	_____	_____	_____
D)	_____	_____	_____

Are You Still Working For The Same Employer Where Your Work Injury Occurred? \_\_\_ YES \_\_\_ NO  
**If 'NO'**, Answer The Questions Below. **If 'YES'**, Skip The Following Questions And Go To The Next Section Entitled '**PAST MEDICAL HISTORY.**'

Why Aren't You Working For The Same Employer Now? \_\_\_\_\_

When Did You Stop Working For The Same Employer? \_\_\_\_\_

If You Are Not Working For The Same Employer As When You Were Injured, **Please List Your Employment Since Leaving:** \_\_\_ I Have Not Worked Since Leaving That Employment

	<u>Employer</u>	<u>Dates Of Employment</u>	<u>Job Title/Duties</u>
A)	_____	_____	_____
B)	_____	_____	_____
C)	_____	_____	_____
D)	_____	_____	_____

Who Is Your **Current Employer(s)**? \_\_\_\_\_

Are You Doing The Same Type Of Work? \_\_\_ YES \_\_\_ NO

**If 'NO'**, Describe The Type Of Work You Are Doing Now, Including Details On Physical Activity:

Has Any **NEW** Job Or Employment **Contributed To, Or Further Worsened Your Condition?**  
\_\_\_ YES \_\_\_ NO If 'YES', Please Name The Employer(s) And Explain How?

Are You Going To Be **Retained For Another Job/Occupation** As A Result Of This Work Injury?  
\_\_\_ YES \_\_\_ NO \_\_\_ I DO NOT KNOW \_\_\_ RECOMMENDED Please Describe:

**PAST MEDICAL HISTORY:**

Please List Information Below With Approximate Dates. **Leave Blank If Denied.**

Childhood Illnesses/Injuries: \_\_\_\_\_  
Allergies: \_\_\_\_\_ Medications: \_\_\_\_\_  
Surgeries: \_\_\_\_\_ Adult Illnesses: \_\_\_\_\_

### **FAMILY HISTORY:**

List Any Health Problems In **Your Immediate Family:** (Mother, Father, Brother, Sister)

\_\_\_\_\_

### **REVIEW OF SYSTEMS:**

Please List Any Problems That You **Now Have** With The Following Body/Organ Systems:

Ears/Nose/Throat: \_\_\_\_\_ Eyes: \_\_\_\_\_  
Lungs: \_\_\_\_\_ Liver: \_\_\_\_\_  
Stomach/Intestines: \_\_\_\_\_ Kidney/Bladder: \_\_\_\_\_  
Reproductive System: \_\_\_\_\_ Psychological: \_\_\_\_\_  
Neurological: \_\_\_\_\_ Heart/Circulation: \_\_\_\_\_

### **OFF WORK ACTIVITIES:**

Do You Exercise? \_\_\_ YES \_\_\_ NO If 'YES', Please Describe Type & Frequency. If 'NO', Please Explain Why You Don't: \_\_\_\_\_

Do You Participate In Any Sports Activities? \_\_\_ YES \_\_\_ NO If 'YES', Please Describe Type & Frequency: \_\_\_\_\_

Do You Have Any Hobbies? \_\_\_ YES \_\_\_ NO If 'YES', Please Describe Type & Frequency: \_\_\_\_\_

Are You Able To Perform Your Normal/Regular Household Chores/Activities? \_\_\_ YES \_\_\_ NO  
If 'NO', Please Explain What You Cannot Do & Why: \_\_\_\_\_

### **SOCIAL HISTORY:**

Are You? ( ) Married ( ) Single ( ) Separated ( ) Divorced ( ) Widowed

How Many Years Of Schooling Have You Had? \_\_\_\_\_

List Degrees, Diplomas, Licenses, Certifications You Hold: \_\_\_\_\_

Do You Use Alcohol? \_\_\_ YES \_\_\_ NO If 'YES', How Many Drinks Per Week? \_\_\_\_\_

Do You Use Tobacco? \_\_\_ YES \_\_\_ NO If 'YES', What Kind & Times Per Day Or Week? \_\_\_\_\_

Do You Use Recreational Drugs? \_\_\_ YES \_\_\_ NO If 'YES', What Kind & How Many Times Per Day Or Week? \_\_\_\_\_

**Injured Worker's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE**

**PHYSICIAN USE ONLY**

PHYSICAL EXAMINATION FINDINGS

DIAGNOSTIC TESTING

DIAGNOSIS

DISCUSSION

PERMANENT AND STATIONARY STATUS

CAUSATION - APPORTIONMENT

VOCATIONAL REHABILITATION

IMPAIRMENT RATING (Impairment Report)

FUTURE MEDICAL CARE

COMPLIANCE STATEMENTS

SIGNATURE, COUNTY & DATE