

Work Comp History

Patient _____

Address _____ City _____ Phone() _____

Age _____ Date of Birth _____ Sex _____ SS# _____

Name of Compensation Carrier _____ City _____ State _____ Zip _____

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? ()Yes ()No

3. Previous Workers Compensation Injury? ()Yes ()No

4. Accident Reported to Employer? ()Yes ()No Name of Person reported accident to _____

5. Injured at: _____

6. Length of time worked there prior to accident _____

7. Type of work being done at the time of injury _____

8. In you own words, please describe the accident _____

9. Have you been treated by another doctor for this accident? ()Yes ()No

If yes, please give the doctor's name and address _____

10. Are you ()Improved ()Changed ()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 ()Every other week

()Monthly ()Other

Does physical therapy help? ()yes ()No ()Don't know

13. Prior to this accident, have you ever had any physical complaints similar to those that you have now?

()Yes ()No ()Don't know

If yes, please describe _____

Were these similar complaints the result of a previous accidents)? ()Yes ()no

Please provide the details of accident(s): _____

NECK PAIN

1. My neck pain began: () Gradually () Suddenly
2. I have pain: () Sometimes () All 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
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
Stand: 1 2 3 4 5 6 7 8
Walk: 1 2 3 4 5 6 7 8

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 () () () ()

14. Have you had any other serious accidents which require medical care? ()Yes ()No

Describe: _____

15. Had you had any serious illness that required hospitalization? ()Yes ()No

Describe: _____

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

If yes, please list type of surgery and date: _____

17. Have you had nervous or mental illness? ()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 the accident? ()Yes ()No

20. What date did you return to work? _____

Patient's Signature _____ Date _____