WORKERS' COMPENSATION QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY. (PLEASE PRINT)

Name:____SSN:___________________________Birthdate:_____________Age:_______

Address:____Phone:___________________Cell:_________________

Name of Compensation Insurance Carrier:____Phone:________________________________

Address of Carrier:____Date and hour of injury____________________________________

Employer Name:_____________________________________Address_______________________________________Phone:_____________________

Nature of business (E.G. Construction, Manufacturer)_____________________________Your specific job_______________________________________

How long worked for company:____________________Injured at (Full address):____

Did you report accident to employer? ☐ yes ☐ no Name of person reported to: ____

In your own words, describe type of work being done at the time of injury, and how accident happened:____

____

____

Where did you feel pain immediately after accident?____

Did you go to the hospital? ☐ yes ☐ no Date Admitted:___________________________________ Date Discharged: _____________________________

Have you lost any time from work? ☐yes ☐ no If yes, list all dates lost from work: ____

If still off work, last date worked____List date returned to work:____________________________________

Due to accident are you currently working reduced hours or light duty? Explain____

Did you consult any other Doctor? ☐yes ☐ no If yes, Name & Address:____

Doctor's diagnosis_____________________________________Treatment received__________________________________How long:_______________

Have you had physical therapy or Rehab? ☐yes ☐ no If yes, how often? ___________________________________Did it help? ☐yes ☐ no ☐ don't know

Are your work activities restricted as a result of this accident? ☐ yes ☐ no Which ones:____

Since this injury are your symptoms ☐ improving ☐ getting worse ☐ the same, Explain:____

What types of medication are you taking?____Do these medicines help? ☐ yes ☐ no ☐ don't know

Have you injured this area before? ☐ yes ☐ no If yes, when?___________________________If injured before did you lose time from work? ☐ yes ☐ no

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: _______

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Were these similar complaints the result of a previous accident(s)? ☐ yes ☐ no If yes, provide details of accident: _________________________________

____

Do any other diseases or accidents affect your employment? ☐ yes ☐ no If yes, explain:____

In your work do you have to favor any part of your body? ☐ yes ☐ no If yes, explain:____

Do you have a history of absenteeism caused from accidents on the job? ☐ yes ☐ no If yes, explain:____

Have you ever had a Workmen's Compensation claim before? ☐ yes ☐ no Describe:____

Before the injury were you capable of working on an equal basis with others your age? ☐ yes ☐ no

Have you retained an attorney? ☐ yes ☐ no Attorney's Name:____

Attorney's address: ____ phone:__________________________

CIRCLE SYMPTOMS YOU HAVE NOTICED SINCE YOUR ACCIDENT

GENERAL SYMPTOM SURVEY

HEADACHES
LOSS OF MEMORY
LIGHT-HEADEDNESS
TENSION
FAINTING
EYE COMPLAINTS
BLURRED VISION
LOSS OF BALANCE
DIZZINESS
LOSS OF HEARING
LOSS OF SMELL
LOSS OF TASTE
PAIN IN THE EARS
IRRATIBILITY
DEPRESSION
MOOD OR BEHAVIOR CHANGES
INSOMNIA
LOSS OF WEIGHT
EAR NOISES
LIGHTS BOTHER EYES
FACE FLUSHED
FACIAL MUSCLE DISTURBANCES
NASAL DISTURBANCES
JAW PAIN
HEAVINESS OF HEAD
NAUSEA
UPSET STOMACH
COLD SWEATS
FATIGUE
ABDOMINAL DISCOMFORT
CONSTIPATION
DIARRHEA
ANXIETY
LACERATIONS
BROKEN BONES
NERVOUSNESS OR RESTLESSNESS
LOSS OF APPETITE
BRUISES
INCREASED RESPIRATION
INABILITY TO CONCENTRATE
HEART PALPITATION
RAPID HEART BEAT
AFRAID OF AUTOMIBILES
AFRAID OF DRIVING
TREMORS
TWITCHES
LOSS OF NORMAL SEX FUNCTION
MENTAL DULLNESS
BLACKOUTS /FAINTING

NEURO-MUSCULOSKELETAL SYSTEM SURVEY

NECK PAIN
STIFFNESS OF NECK
SORENESS OF NECK
DIFFICULT NECK MOVEMENT
MUSCLE SPASM IN NECK
GRINDING SOUND IN NECK
DIFFICULTY SWALLOWING
SHOULDER JOINT PAIN
PAIN BETWEEN SHOULDERS
CAN NOT RAISE ARM OR HAND
MUSCLE SPASM IN SHOULDERS
COLD HANDS
ELBOW, FINGER OR WRIST PAIN
SHORTNESS OF BREATH
RIB PAIN
CHEST PAIN
TROUBLE BREATHING
NUMBNESS, PAIN OR TINGLING IN ARMS, HANDS OR FINGERS
PAINFUL TAILBONE
LOW BACK PAIN
DIFFICULTY STANDING ERECT
BACK AGGRAVATED BY WORKING, LIFTING, STOOPING, SITTING, BENDING, COUGHING, OR LYING
NUMBNESS, PAIN, OR TINGLING IN EITHER LEG
MUSCLE SPASM IN LEG
PAIN IN BUTTOCKS, KNEES, CALF, ANKLE, FOOT OR TOES
COLD FEET
SWOLLEN ANKLES
PAIN IN HIP
DIFFICULTY WALKING
FREQUENT OR DIFFICULT URINATION

CURRENT SYMPTOMS, OTHER THAN ABOVE ____________________

Relate your before and after capacity for performing such activities as: (Circle)

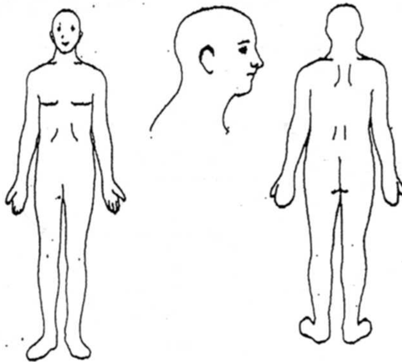
BEFORE

Walking	normal	limited	difficult	painful
Standing	normal	limited	difficult	painful
Bending	normal	limited	difficult	painful
Sitting	normal	limited	difficult	painful
Stooping	normal	limited	difficult	painful
Lifting	normal	limited	difficult	painful
Twisting	normal	limited	difficult	painful
Lying	normal	limited	difficult	painful

AFTER

Walking	normal	limited	difficult	painful
Standing	normal	limited	difficult	painful
Bending	normal	limited	difficult	painful
Sitting	normal	limited	difficult	painful
Stooping	normal	limited	difficult	painful
Lifting	normal	limited	difficult	painful
Twisting	normal	limited	difficult	painful
Lying	normal	limited	difficult	painful

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW:



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Signature____________________ Date____________________