

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: _____

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
 IRRITABILITY
 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 AUTOMOBILES
 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

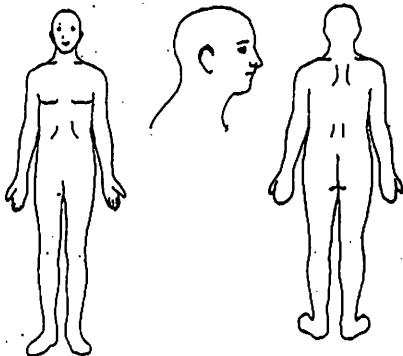
DIFFICULTY SWALLOWING
 SHOULDER JOINT PAIN
 PAIN BETWEEN SHOULDERS
 CAN NOT RAISE ARM OR HAND
 MUSCLE SPASM IN SHOULDERS
 COLD HANDS
 ELBOW, FINGER OR WRIST PAIN
 SHORTNESS OF BREATH
 RIB PAIN
 CHEST PAIN
 TROUBLE BREATHING
 NUMBNESS, PAIN OR TINGLING IN ARMS, HANDS OR FINGERS
 PAINFUL TAILBONE
 LOW 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 | | | | | AFTER | | | |
|----------|--------|---------|-----------|---------|----------|--------|---------|-----------|---------|
| Walking | normal | limited | difficult | painful | Walking | normal | limited | difficult | painful |
| Standing | normal | limited | difficult | painful | Standing | normal | limited | difficult | painful |
| Bending | normal | limited | difficult | painful | Bending | normal | limited | difficult | painful |
| Sitting | normal | limited | difficult | painful | Sitting | normal | limited | difficult | painful |
| Stooping | normal | limited | difficult | painful | Stooping | normal | limited | difficult | painful |
| Lifting | normal | limited | difficult | painful | Lifting | normal | limited | difficult | painful |
| Twisting | normal | limited | difficult | painful | Twisting | normal | limited | difficult | painful |
| Lying | normal | limited | difficult | painful | Lying | normal | limited | difficult | painful |

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW:



Signature _____ Date _____