

# WORKER'S COMPENSATION QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Date \_\_\_\_\_  
Patient \_\_\_\_\_ No. \_\_\_\_\_  
Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Occupation \_\_\_\_\_  
Type of work you do (labor) \_\_\_\_\_  
Who referred you to our office? \_\_\_\_\_  
Social Sec.# \_\_\_\_\_ Business Phone \_\_\_\_\_ Company Name \_\_\_\_\_  
Company Address \_\_\_\_\_  
Please explain in detail how your injury occurred? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Give time and date present injury occurred \_\_\_\_\_  AM  PM \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Where did you feel pain immediately after the accident? \_\_\_\_\_  
Did you return to work?  Yes  No If so, date returned to work \_\_\_\_\_  
Did you consult any other doctor?  Yes  No  
Did employer send you to doctor?  Yes  No  
If so, give doctor's name \_\_\_\_\_  D.C.,  M.D.,  D.O.,  D.D.S. \_\_\_\_  
Doctor's diagnosis \_\_\_\_\_  
Have you ever injured this area before?  Yes  No If so, when \_\_\_\_\_  
Did you lose time from work?  Yes  No  
What medications are you presently taking? \_\_\_\_\_  
\_\_\_\_\_  
Do any other diseases or accidents affect your employment?  Yes  No If so, explain \_\_\_\_\_  
\_\_\_\_\_

In your work, do you have to favor any part of your body?  Yes  No If so, explain \_\_\_\_\_  
\_\_\_\_\_  
Have you ever had a Worker's Compensation claim before?  Yes  No  
Before the injury, were you capable of working on an equal basis with others your age?  Yes  No  
Are your work activities restricted as a result of this accident?  Yes  No  
Have you ever had a Worker's Compensation claim before?  Yes  No  
Since the injury, are your symptoms  Improving?  Getting worse?  The same?  
Have you retained an attorney?  Yes  No Litigation?  Yes  No  
If so, name, address & phone # \_\_\_\_\_

PLEASE DO NOT WRITE BELOW THIS LINE

This injury was verified by \_\_\_\_\_ on \_\_\_\_\_  
Name of supervisor who verified the injury: \_\_\_\_\_  
Time of call \_\_\_\_\_

# HEALTH QUESTIONNAIRE

PLEASE CHECK MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING

Date: \_\_\_\_\_

Patient: \_\_\_\_\_

No.: \_\_\_\_\_

## MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

## GENTO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

### FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

### ARE YOU PREGNANT?

- Yes  No

## GASTRO-INTESTINAL SYSTEM

- Poor Appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

## NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

## HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Exercise
- Drug Abuse
- \_\_\_\_\_

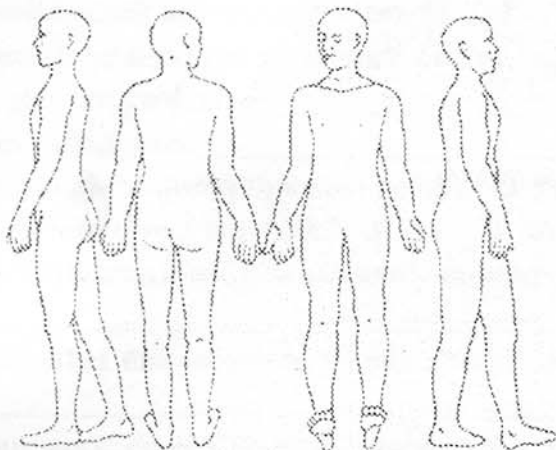
## CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

## EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw Pain

### SYMPTOM LOCALIZATION



P \_\_\_ Pain  
N \_\_\_ Numb  
S \_\_\_ Spasm  
T \_\_\_ Tender  
H \_\_\_ Hypoesthesia

### Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature \_\_\_\_\_

..... DO NOT WRITE BELOW THIS LINE .....

Patient accepted?  Yes  No Doctor's Signature \_\_\_\_\_