Workers’ Compensation Patient Questionnaire

Name: ____________________________ Date: ______________

Age: _____ Sex: _______ Right / Left Handed (circle one)

Please fill out this entire questionnaire so that we may have the most accurate information concerning your injury.

CURRENT COMPLAINTS

What medical problem(s) is the doctor to see you for today? Please briefly describe your current complaints below.

1. 
2. 
3. 
4. 
5. 
6. 

INITIAL HISTORY OF INJURY

1. When did you first notice this medical problem? Date: __________
   (Whether you paid attention to this condition or not.)

2. What do you feel caused this condition? __________________________
   ______________________________________________________
   ______________________________________________________

3. Who was your employer at the time you noticed this condition?
   ______________________________________________________

   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

5. What were the immediate symptoms? __________________________
   ______________________________________________________

6. Did you finish what you were doing? Yes / No
7. Did you report the injury or problem?  
   Yes / No
   If yes, when: ____________________  
   To whom: ____________________

HISTORY OF TREATMENT

1. When did you first see a doctor for this problem? ____________________
2. To which hospital or clinic were you taken? ____________________
3. Were you sent by your employer?  
   Yes / No
   If yes, please indicate which tests were done below.
4. Name of the doctor you saw? ____________________
   What type of doctor? ____________________
5. Were tests done?  
   Yes / No
   X-rays  EMG  Nerve Tests  MRI  Other:
2. What did the tests show? ____________________
3. What recommendations were made or what treatment was prescribed?
   a. Off work (dates): ____________________
   b. Hospitalized (give dates): ____________________
   c. Physical therapy (give dates, how often): ____________________
   d. Medication (give names): ____________________
   e. Casting:  
      Yes / No  
      Splinting:  
      Yes / No
   f. Surgery (what kind, dates): ____________________

List all other doctors that you have seen for this injury:

Doctor’s name: ____________________  
   Type of doctor: ____________________
Date last seen: ____________________  
   were tests done? ____________________
What did the test(s) show? ____________________
What treatment was given? ____________________
Hospitalized (dates): ____________________
Physical therapy (duration & frequency): ____________________
Medication (names): ____________________  
   Casting:  
      Yes / No  
      Splinting:  
      Yes / No
Surgery (type(s) & date(s)): ____________________
Which treatment helped? ____________________________________________

**Doctor’s name:** ______________________ **Type of doctor:** ______________

**Date last seen:** ______________________ **were tests done?** ______________

What did the test(s) show? ____________________________________________

What treatment was given? ____________________________________________

**Hospitalized (dates):** ____________________________________________

**Physical therapy (duration & frequency):** _____________________________

**Medication (names):** ______________ **Casting:** Yes / No **Splinting:** Yes / No

**Surgery [type(s) & date(s)]:** _______________________________________

Which treatment helped? ____________________________________________

**Doctor’s name:** ______________________ **Type of doctor:** ______________

**Date last seen:** ______________________ **were tests done?** ______________

What did the test(s) show? ____________________________________________

What treatment was given? ____________________________________________

**Hospitalized (dates):** ____________________________________________

**Physical therapy (duration & frequency):** _____________________________

**Medication (names):** ______________ **Casting:** Yes / No **Splinting:** Yes / No

**Surgery [type(s) & date(s)]:** _______________________________________

Which treatment helped? ____________________________________________

Name of the doctor that you are currently seeing for this problem:
_________________________________________________________________

Has your doctor released you to return to work? Yes / No
If YES, when were you released? ________________________________

Were you released to full duty or light duty? Full / Light
If LIGHT duty, what were your restrictions? __________________________

When did you actually return to work? ________ Are you still working? Yes / No
If NO, state reason: _______________________________________________
Are you working at your same job?  Yes / No

Are you working a different job?  Yes / No

How is the work different from your previous job?  __________________________

__________________________

WORK RECORD SINCE INJURY

Have you missed any work because of the injury?  Yes / No

List all dates that you have not been working.

From _______ to _______  From _______ to _______
From _______ to _______  From _______ to _______

JOB DESCRIPTION

Job title at the time of your injury:  __________________________

Employer at the time of your injury:  __________________________

Hours worked per day ______Days worked per week ______ Overtime hours per week____

Work duties (describe what you do during an average work day):

__________________________

__________________________

Maximum amount of weight that you would lift by yourself:  ______________

How many times per day would you have to lift this amount?  ______________

List any machines or tools that you routinely used at work:  __________________________

Check any activities required in the course of your work:

_____ Lift  _____ Carry  _____ Bend  _____ Stoop

_____ Squat  _____ Push  _____ Pull  _____ Climbing

_____ Walk  _____ Sit  _____ Stand

_____ Operate Equip.  _____ Operate Equip.  _____ Exposure

_____ Tools – Hand  _____ Tools – Power  _____ Repetitive Use

_____ Reach Forward  _____ Reach Overhead  _____ Awkward Positions
Number of years that you have worked for this employer: ________________

Number of years that you have been in this line of work: ________________

**PAST MEDICAL HISTORY**

Have you had previous injuries to any parts of your body involved in this claim?  **Yes / No**
   If yes, explain:

Have you ever had any other work related injuries?  **Yes / No**
   If yes, list dates and injuries:

Have you ever been hospitalized?  **Yes / No**
   If yes, list dates and reasons:

Have you ever had surgery?  **Yes / No**
   If yes, list date(s) and procedure(s):

List any motor vehicle accidents for which you received treatment:
________________________________________________________________________
________________________________________________________________________

List current medications:                                                                 List any allergies to medications:
________________________________________________________________________   (Including adhesives, injectables or shellfish?)
________________________________________________________________________
________________________________________________________________________

Check any of the following conditions which you have now or had in the past:

_____ Diabetes    _____ Thyroid Problems    _____ Rheumatoid Arthritis

_____ Heart Attack   _____ Stomach Ulcers    _____ Tuberculosis

_____ Cancer        _____ Kidney Problems    _____ High Blood Pressure

_____ Stroke        _____ Liver Disease

Please List any other medical conditions:
SOCIAL HISTORY

Check one of the following:

- Married
- Single
- Divorced
- Separated
- Widow

Do you have any children? Yes / No
If yes, how many? ________________

Your date of birth: ________________ Where you born? ________________

Highest education completed: ______________________________________

Have you attended trade school? Yes / No

Hobbies: Yes / No
If yes, what kind? _____________________________________________

Recreational Activities: _________________________________________

How much do you smoke? __________ For how long? ________________

How much do you drink? __________ For how long? ________________

Have you ever done any street drugs? Yes / No
If yes, what kind and how long ago? _______________________________

Have you ever been in an alcohol or drug rehabilitation program? Yes / No

MILITARY HISTORY

- None
- Navy
- Army
- Marine Corps
- Air Force
- Coast Guard
- National Guard

Years of service: ____________ Date of discharge: ________________

PATIENT SIGNATURE: _________________________________________

DATE OF FORM COMPLETION: _________________________________