WORKER'S COMPENSATION INJURY QUESTIONNAIRE

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Mesa, AZ 85206

Today's Date: _____
Time: _____
Received by: _____

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

Patient's Name:_____

Employer's Information at time of Accident:
Business Name:_____ Phone:_____
Address_____ City_____ State _____ Zip_____

Patient's Occupation:_____
Previous Worker's Compensation Injury? ❑Yes ❑No Impairment Rating:_____

Length of time at this job prior to injury:_____
Date of Injury:_____ Time of injury:_____ Last Date Worked:_____

Please explain what you were doing at the time you were injured and how the accident happened (lifting, bending, walking, carrying standing, etc.):

_____
_____
_____

When did the pain begin?(please be specific):

_____

Where did you first feel it?(please be specific):

_____

Was the pain intense at first or did it gradually worsen?

_____

REPORT ACCIDENT/ACCIDENT OBSERVER
What date did you report this injury on?

_____

Who did you report this injury to?_____
What is Their Position?_____
Did anyone else observe accident/injury? ❑Yes ❑No
If yes, Name:_____
What is Their Position?_____

SYMPTOMS FROM ACCIDENT
Did you experience bleeding cuts or bruises? ❑Yes ❑No
If bleeding cuts where?_____ If bruises, where?_____

Please describe how you felt. PLEASE BE SPECIFIC.
Immediately after the accident:_____
Later that ❑Day ❑Night:_____
The next day(s):_____
_____

Check symptoms that have become apparent since the accident/injury:
❑Nervousness ❑Loss of balance ❑Sleeping trouble ❑Headache ❑Neck Pain/Stiffness
❑Loss of smell ❑Toe Numbness ❑Fainting ❑Midback Pain ❑Loss of taste ❑Finger Numbness

Check symptoms that have become apparent since the accident/injury: (cont.)
❑Anxiety ❑Low Back Pain ❑Loss of memory ❑Cold Hands ❑Seizures ❑Eyes sensitive to light
❑Pins & Needles - Arms ❑Cold Feet ❑Visual disturbance ❑Pain behind eyes
❑Pins & Needles - Leg ❑Chest Pain ❑Forgetfulness ❑Dizziness ❑Shortness of breath
❑Constipation ❑Blurred Vision ❑Cold sweats ❑Head seems too heavy ❑Diarrhea
❑Double Vision ❑Face flushed ❑Irritability ❑Fatigue ❑Confused ❑Ringing/Buzzing Ears
❑Depression ❑Tension ❑Disoriented ❑Fever ❑Other_____

MECHANISM OF INJURY:
Please explain the mechanism of the injury *(only fill in those sections that apply to you)*:
FALL:
Did you hit anything when you fell? ❑Yes ❑No
If yes, what? _____
Were you carrying anything when you fell? ❑Yes ❑No
If yes, what? _____
How much did it weigh? _____lbs.
Did you twist when you fell? ❑Yes ❑No
If so, to which side? ❑Left ❑Right
Was the area lighted? ❑Yes ❑No
Describe the condition of the area (slippery, graveled, etc.)
_____
What part of the body did you fall on?
_____
How far did you fall? (In feet)
_____
What did you land on?
_____

LIFT/PULL:
How much did the object weigh?_____lbs.
Did you fall after the injury? ❑Yes ❑No
If yes, how far? _____
Did you hit anything when you fell? ❑Yes ❑No
If yes, what? _____
Were you twisting when you were lifting/pulling? ❑Yes ❑No
If yes, to which side? ❑Left ❑Right
How far off the ground did you have the object before the pain started?
_____
Did you drop the object when the pain started? ❑Yes ❑No
Did it land on you? ❑Yes ❑No Where?_____
Did you lift with your ❑Legs ❑Back ❑Other_____

BEND:
Were you lifting when you were bent over? ❑Yes ❑No
If yes, how much did the object weigh?_____lbs.
How far were you bent over?_____
Did you fall when the pain started? ❑Yes ❑No
How far?_____
Were you twisting when you bent forward? ❑Yes ❑No
Toward which side? ❑Left ❑Right
Did you land on anything? ❑Yes ❑No
If so, what?_____

WORK STATUS HISTORY:
Have you lost time from work as a result of this new injury? ❑Yes ❑No
If yes, please give dates:_____
Have you gone back to work? ❑Yes ❑No
When:_____
If yes, status or work: ❑Modified ❑Regular

List restrictions you have been placed on:_____
If you have gone back to work, list activities that are:
PAINFUL:_____
DIFFICULT:_____
If you are currently on disability (time loss), do you want to go back to work doing your regular job? ❑Yes ❑No If no, why not?_____
Are there any problems you have with a fellow employee, supervisor, or manager that needs to be discussed? ❑Yes ❑No If yes, please explain:_____

FIRST DOCTOR/HOSPITAL/CLINIC:
Were you hospitalized as a result of this accident? ❑Yes ❑No
If yes, where:_____ Doctor Name:_____
Date of First Visit:_____
Were you examined? ❑Yes ❑No Were X-rays taken? ❑Yes ❑No
What diagnosis did the doctor give you?_____
Were you given treatment? ❑Yes ❑No
If yes, what type?_____
What benefits did you receive from this treatment?_____
_____
Date of last treatment?_____
Did the doctor refer you to another health professional? ❑Yes❑No
If yes, to whom and for what?_____
Did you follow the doctor's recommendation? ❑Yes ❑No
If no, why not?_____

SECOND DOCTOR/CLINIC:
Doctor Name:_____ Date of First Visit:_____
Were you examined? ❑Yes ❑No Were X-rays taken? ❑Yes ❑No
What diagnosis did the doctor give you?_____
Were you given treatment? ❑Yes ❑No
If yes, what type?_____
What benefits did you receive from this treatment?_____
_____
Were you given treatment? ❑Yes ❑No
If yes, what type?_____
What benefits did you receive from this treatment?_____
_____
Date of last treatment?_____
Did the doctor refer you to another health professional? ❑Yes❑No
If yes, to whom and for what?_____
Did you follow the doctor's recommendation? ❑Yes ❑No
If no, why not?_____

PRIOR SIMILAR SYMPTOMS:
Did you have any physical complaints just before the accident? ❑Yes ❑No
If yes, please describe in detail:_____
_____
_
Have you ever had any prior injuries, accidents, diseases or treatment to the area of your body now affected? ❑Yes ❑No
If yes, what part was previously injured?_____
Date previously injured?_____
Describe previous injury:_____
Were you treated? ❑Yes ❑No By whom?_____
Date treatment began:_____ Date treatment ended:_____
The last date you felt pain or problems from that previous injury:_____

JOB DESCRIPTION

In terms of an 8 hour workday:
Occasionally = 33%, ***Frequently*** = 34% to 66%, ***Continuously*** = 67% to 100%
In a typical 8 - hour workday, I (circle the number of hours of activity):

Sit	1	2	3	4	5	6	7	8	Hours
Stand	1	2	3	4	5	6	7	8	Hours
Walk	1	2	3	4	5	6	7	8	Hours

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	❑	❑	❑	❑
Pulling/Pushing	❑	❑	❑	❑

On the job, I lift:

	Not at all	Occasionally	Frequently	Continuously
Up to 10 pounds	❑	❑	❑	❑
11 to 24 pounds	❑	❑	❑	❑
25 to 34 pounds	❑	❑	❑	❑
35 to 50 pounds	❑	❑	❑	❑
51 to 74 pounds	❑	❑	❑	❑
75 to 100 pounds	❑	❑	❑	❑

Are you required to bend over while doing any lifting? ❑Yes ❑No
Are your feet used in repetitive movements, such as operating foot controls? ❑Yes ❑No

Do you use your hands for repetitive actions such as:

	Simple Grasping	Firm Grasping	Find Manipulating
Right Hand	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
Left Hand	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No

Are you required to work at unprotected heights? ❑Yes ❑No
If yes, please describe:_____
Are you required to be around moving machinery? ❑Yes❑No
If yes, please describe:_____
Are you exposed to marked changes in temperature and humidity? ❑Yes ❑No
If yes, please describe:_____
Are you required to drive automotive equipment? ❑Yes ❑No
If yes, please describe:_____
Are you exposed to dust, flames, and/or gases? ❑Yes ❑No
If yes, please describe:_____
Please list any additional comments:_____
_____

Patient's
Signature:_____**Date**:_____