WORK/COMP HISTORY

Patient _____
Telephone _____
Address _____
City _____
State _____
Zip _____
Age ____ Date of Birth _____ Sex _____ SSN _____
Name of Compensation Carrier _____
Telephone _____
Address of Carrier _____
City _____
State _____
Zip _____
Employer's Name _____
Telephone _____
Address of Employer_____
City _____
State _____
Zip _____

1. Type of Business _____
   Your Occupation _____
2. Date Injured _____ Hour _____AM/PM
   Last Date Worked _____
   Are you off work? ( )Yes ( )No
3. Previous Workers' Compensation Injury ( )Yes ( )No
4. Accident reported to employer? ( )Yes ( )No
   Name of person reported accident to: _____
5. Injured at: _____
   City_____
   State _____
   Zip_____
6. Length of time worked there prior to accident: _____
7. Type of work being done at time of injury: _____
_____
8. In your own words, please describe accident: _____
_____
9. Have you been treated by another doctor for this accident? ( )Yes ( )No
If yes, please list doctor's name and address: _____
_____
10. Are you: ( ) improved ( ) unchanged ( ) getting worse
11. What types of medications are you taking? _____
_____
Do these medications help? ( )Yes ( ) No ( ) Don't know

12. Have you had physical therapy? ( ) Yes ( ) No If yes, how often?
( )Daily ( )Every Other Day ( )Several times a week ( ) Weekly
( ) Every other week ( ) Monthly ( ) Other _____
13. 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 there similar complaints the results of a previous accident(s)?
( ) Yes ( ) No
Please provide details of accident(s): _____
_____
14. Have you had any other serious accidents which required medical care?
( ) Yes ( ) No
Describe: _____
15. Have you had any serious illnesses that required hospitalization? ( ) Yes ( ) No
Describe: _____
_____
_____
16. Have you had any surgeries: ( ) Yes ( ) No
If yes, list type of surgery and date: _____
_____
17. Have you had any nervous or mental illnesses? ( ) Yes ( ) No
Have you had psychiatric care? ( ) Yes ( ) No
18. Have you received a medical discharge from the Armed Forces? ( ) Yes ( ) No
19. Have you returned to work since this accident? ( ) Yes ( ) No
If you have returned to work since your accident, please fill out the information below:

Date	Employer	Occupation	Light/Reg. Duty	Full/Part Time

CURRENT MEDICAL COMPLAINTS

BACK PAIN:

1. Currently, I have pain in my: ( ) low back ( ) mid back ( ) upper back
2. My pain began: ( ) gradually ( ) suddenly
3. I have pain: ( ) sometimes ( ) all of the time
4. My pain goes into my: ( ) right leg ( ) left leg ( ) both
5. I have tingling and/or Numbness in my: ( ) right leg ( ) left leg ( ) both

6.	My pain is worse when I:		
	Cough or sneeze	( ) Yes	( ) No
	Sit	( ) Yes	( ) No
	Bend	( ) Yes	( ) No
	Walk	( ) Yes	( ) No
	Lift	( ) Yes	( ) No
	Push	( ) Yes	( ) No
	Pull	( ) Yes	( ) No
7.	My back is worse with sexual activity	( ) Yes	( ) No
8.	My pain wakes me up during the night	( ) Yes	( ) No
9.	Changes in the weather affect my pain	( ) Yes	( ) No

NECK PAIN:

1.	My neck pain began:	( ) gradually	( ) suddenly	
2.	I have pain:	( ) sometimes	( ) all of the time	
3.	My pain goes into my:	( ) right arm	( ) left arm	( ) both
4.	I have tingling and/or Numbness in my:	( ) right arm	( ) left arm	( ) both
5.	My pain is worse when I:			
	Cough or sneeze	( ) Yes	( ) No	
	Bend forward	( ) Yes	( ) No	
	Lift	( ) Yes	( ) No	
	Push	( ) Yes	( ) No	
	Pull	( ) Yes	( ) No	
	Turn my head	( ) Yes	( ) No	
6.	My pain wakes me up During the night	( ) Yes	( ) No	
7.	Changes in the weather Affect my pain	( ) Yes	( ) No	
8.	I have neck stiffness	( ) Yes	( ) No	
9.	I have headaches	( ) Yes	( ) No	
10.	If I do get headaches, They occur:	( ) sometimes	( ) all of the time	

OTHER PAIN:

Please describe any current medical complaints which you are experiencing and were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition:

_____
_____
_____
_____

JOB DESCRIPTION:
(In terms of a 8-hour workday, "occasionally" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day).

1. In a typical 8-hour workday, I: (Circle # of hours/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

2. 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	( )	( )	( )	( )
Pushing/ Pulling	( )	( )	( )	( )

3. On the job, I lift

	Not at All	Occasionally	Frequently	Continuously
Up to 10lbs.	( )	( )	( )	( )
11 to 24lbs.	( )	( )	( )	( )
12 to 34lbs.	( )	( )	( )	( )
35 to 50 lbs.	( )	( )	( )	( )
51 to 74 lbs.	( )	( )	( )	( )
75 to 100 lbs.	( )	( )	( )	( )

4. Do you have to bend over while doing any lifting: ( ) Yes ( ) No

5. Are your feet used for repetitive movements, such as in operating foot controls:
( ) Yes ( ) No

6. Do you use your hands for repetitive actions, such as:

	Simple Grasping	Firm Grasping	Fine Manipulating
Right Hand	( ) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No
Left Hand	( ) Yes ( ) No	( ) Yes ( ) No	( ) Yes ( ) No

7. Are you required to work on unprotected heights? ( ) Yes ( ) No
Describe:_____
_____
_____

8. Are you required to be around moving machinery: ( ) Yes ( ) No
Describe:_____
_____
_____

9. Are you exposed to marked changes in temperature and humidity? ( ) Yes ( ) No
Describe:_____
_____
_____

10. Are you required to drive automotive equipment: ( ) Yes ( ) No
Describe:_____
_____
_____

11. Are you exposed to dust, fumes and/or gases? ( ) Yes ( ) No
Describe:_____
_____
_____

12. Please list any additional comments:
_____
_____
_____
_____

Signature: _____ Date: _____