Worker's Compensation Injury Questionnaire

Please Print

Name:_____ Today's Date:_____

Employer's Business Name at time of Accident:_____

Employer's Phone:_____ Employer's Address:_____

Occupation:_____ Impairment Rating:_____

Previous Worker's Compensation Injury? ☐ Yes ☐ No

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, walking, carrying standing, etc) _____

_____

When did the pain begin? (Please be specific) _____

When 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? _____ Position? _____

Did anyone else observe accident/injury? ☐ Yes ☐ No If yes, Name:_____

Position: _____

SYMPTOMS FROM ACCIDENT

Did you experience bleeding, cuts or bruises? ☐ Yes ☐ No
If bleeding or 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 been apparent since the accident/injury

☐ Nervousness	☐ Loss of balance	☐ Sleeping Trouble	☐ Headache	☐ Fainting
☐ Neck Pain/Stiffness	☐ Loss of smell	☐ Toe Numbness	☐ Anxiety	☐ Seizures
☐ Ringing/buzzing ears	☐ Loss of taste	☐ Finger Numbness	☐ Cold Hands	☐ Cold Feet
☐ Low Back Pain	☐ Loss of memory	☐ Blurred Vision	☐ Chest Pain	☐ Constipation
☐ Eyes- light sensitive	☐ Pins/Needles –Arms	☐ Diarrhea	☐ Fatigue	☐ Depression
☐ Pain behind eyes	☐ Pins/Needles – Legs	☐ Dizziness	☐ Confused	☐ Disoriented
☐ Shortness of breath	☐ Double Vision	☐ Forgetfulness	☐ Tension	☐ Cold Sweats
☐ Heads seems heavy	☐ Mid back Pain	☐ Face Flushed	☐ Irritability	☐ Fever
☐ Visual Disturbance	☐ Other: _____			

MECHANISM OF INJURY:

Pleases explain the mechanism of the injury (only fill in the sections that apply to you)

FALL

☐ Yes ☐ No Did you hit anything when you fell? If yes, what? _____
☐ Yes ☐ No Were you carrying anything when you fell? If yes, what? _____
How much did it weigh? _____ lbs
☐ Yes ☐ No Did you twist when you fell? If so, to which side? ☐ Left ☐ Right
☐ Yes ☐ No Was the area lighted?

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
☐ Yes ☐ No Did you fall after the injury? If yes, how far? _____
☐ Yes ☐ No Did you hit anything when you fell? If yes, what? _____
☐ Yes ☐ No Were you twisting when you were lifting/pulling? If yes, to which side? ☐ Left ☐ Right

How far off the ground did you have the object before the pain started? _____
☐ Yes ☐ No Did you drop the object when the pain started?
☐ Yes ☐ No Did it land on you? Where? _____
Did you lift your ☐ Legs ☐ Back Other _____

BEND:

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

WORK STATUS HISTORY:

☐ Yes ☐ No Have you lost time from work as a result of this new injury? If yes, give dates: _____
_____
☐ Yes ☐ No Have you gone back to work? When? _____
If yes, status of work: ☐ Modified ☐ Regular
List restrictions that you have been placed on: _____
If you have gone back to work, list the activities that are:
PAINFUL _____
DIFFICULT _____
☐ Yes ☐ No If you are currently on disability (time loss), do you want to go back to work doing your regular job? If no, why not? _____
☐ Yes ☐ No Are there any problems you have with a fellow employee, supervisor, or manager that needs to be discussed? If yes, please explain: _____
_____