Workers' Compensation Questionnaire
Integrated Physical Medicine, LLC

Was your accident directly related to your work? ☐Yes ☐No Date and Time of accident:_____
Briefly describe the events that occurred just before and during your accident:_____

Did you report your accident to your employer? ☐ Yes ☐No Date Reported:_____
Did accident render you unconscious? ☐Yes ☐No
If yes, for how long?_____

Please describe how you felt immediately after the accident:_____

Describe any treatment you received:_____

Were x-rays taken? ☐Yes ☐No
Was medication prescribed? ☐Yes ☐No
If yes, what type:_____

Are your work activities restricted as a result of this injury? ☐Yes ☐No

Indicate the symptoms that are a result of this accident:

☐Dizziness
☐Difficulty Sleeping
☐Arms /Shoulder Pain
☐Upper/Mid Back Pain
☐Memory Loss
☐Irritability
☐Numb Hands/Fingers
☐Lower Back Pain
☐Headache
☐Fatigue
☐Chest Pain
☐Back Stiffness
☐Blurred Vision
☐Tension
☐Shortness of Breath
☐Numb Feet/Toes
☐Ears Ringing/Buzzing
☐Neck Pain
☐Stomach Upset/Nausea
☐Stiff Neck
☐ Jaw Problems
☐Leg Pain
☐Other:

Is your condition getting worse? ☐Yes ☐No

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on Back	☐	☐	☐
Lying on Side	☐	☐	☐
Lying on Stomach	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Sexual Activity	☐	☐	☐
Walking Short Distance	☐	☐	☐
Running	☐	☐	☐
Sports	☐	☐	☐
Bending Forward	☐	☐	☐
Operating Equipment	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐
Lifting	☐	☐	☐
Driving	☐	☐	☐
Twisting	☐	☐	☐
Crawling	☐	☐	☐
Working	☐	☐	☐
Lifting	☐	☐	☐
Typing	☐	☐	☐
Stooping	☐	☐	☐

Signature: _____ **Date:** _____

Please note this form is to be used in conjunction with any forms required by your state's workers' compensation board. This form is not intended to be a substitute for any state or other authority's forms.