WORK/COMP HISTORY

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ S/S# _____

Name of Compensation Carrier: _____ Phone _____

Address of Carrier: _____ City _____ State _____ Zip _____

Employer's Name: _____ Phone # _____

Employer's Address _____ 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 Worker's Compensation Injury? ( ) Yes ( ) No
4. Accident reported to employer? ( ) Yes ( ) No Name of person reported accident _____
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 you 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 medicines are you taking? _____

_____

   Do these medicines 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

   Does the physical therapy help? ( ) Yes ( ) No ( ) Don't know
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 these 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 DUTY REG. DUTY	FULL-TIME 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 an 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 10 pounds	( )	( )	( )	( )
11 to 24 pounds	( )	( )	( )	( )
25 to 34 pounds	( )	( )	( )	( )
35 to 50 pounds	( )	( )	( )	( )
51 to 74 pounds	( )	( )	( )	( )
75 to 100 pounds	( )	( )	( )	( )

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/of gases? ( ) Yes ( ) No

Describe: _____

_____

_____

12. Please list any additional comments: _____

_____

_____

Signature: _____ Date: _____