

# WORKER'S COMPENSATION QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS COMPLETELY

Date \_\_\_\_\_  
Patient \_\_\_\_\_ No. \_\_\_\_\_  
Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Mobile: \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
Occupation \_\_\_\_\_  
Type of work you do (labor) \_\_\_\_\_  
Who referred you to our office? \_\_\_\_\_  
Social Sec. # \_\_\_\_\_ Business Phone: \_\_\_\_\_ Company Name: \_\_\_\_\_  
Company Address \_\_\_\_\_  
Please explain in detail how your injury occurred? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Give time and date present injury occurred \_\_\_\_\_  AM  PM \_\_\_\_/\_\_\_\_/\_\_\_\_  
Where did you feel pain immediately after the accident? \_\_\_\_\_  
Did you return to work?  Yes  No If so, date returned to work \_\_\_\_\_  
Did you consult any other doctor?  Yes  No  
Did employer send you to any other doctor?  Yes  No  
If so, give doctor's name \_\_\_\_\_  D.C.,  M.D.,  D.O.,  D.D.S. \_\_\_\_\_  
Doctor's Diagnosis \_\_\_\_\_  
Did you lose time from work?  Yes  No  
What medications are you presently taking? \_\_\_\_\_  
\_\_\_\_\_

Do any other diseases or accidents affect your employment?  Yes  No If so, explain \_\_\_\_\_  
\_\_\_\_\_

In your work, do you have to favor any part of your body?  Yes  No If so, explain \_\_\_\_\_  
\_\_\_\_\_

Have you ever had a Worker's Compensation claim before?  Yes  No  
Before the injury, were you capable of working on an equal basis with others your age?  Yes  No  
Are your work activities restricted as a result of this accident?  Yes  No  
Since the injury, are your symptoms  Improving?  Getting worse?  The same?  
Have you retained an attorney?  Yes  No Litigation?  Yes  No  
If so, name, address & phone # \_\_\_\_\_  
\_\_\_\_\_

PLEASE DO NOT WRITE BELOW THIS LINE

This injury was verified by \_\_\_\_\_ on \_\_\_\_\_  
Name of supervisor who verified the injury: \_\_\_\_\_ Time of call \_\_\_\_\_

# HEALTH QUESTIONNAIRE

Please Check Mark Each of the Conditions Below that You are Currently Experiencing

Date: \_\_\_\_\_

Patient: \_\_\_\_\_ No.: \_\_\_\_\_

## MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

## GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

### FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

ARE YOU PREGNANT?

- YES     NO

## GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

## CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

## EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw Pain

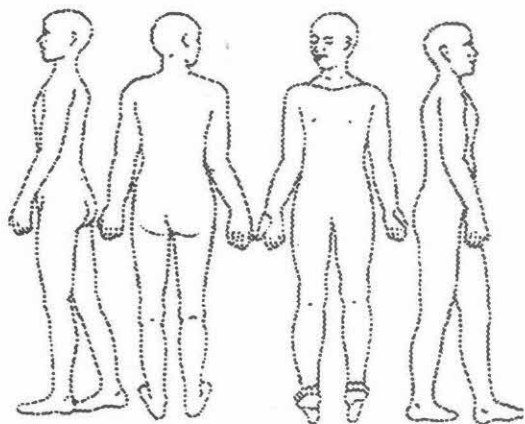
## NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

## HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Drug Abuse
- \_\_\_\_\_

### SYMPTOM LOCALIZATION



- P \_\_\_ Pain                      T \_\_\_ Tender  
 N \_\_\_ Numb                    H \_\_\_ Hypoesthesia  
 S \_\_\_ Spasm

### Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature \_\_\_\_\_

.....DO NOT WRITE BELOW THIS LINE.....

Patient Accepted?     Yes     No    Doctor's Signature \_\_\_\_\_