

Work-Related Injury Questionnaire

Please PRINT CLEARLY - All information is required & kept confidential.

Please provide us with your: • Work Comp Insurance info • Health Insurance cards
• Driver's License • All Medical & Accident Reports

Who referred you to our Center ?

Print Full Name of patient, doctor, attorney, website, directory or event

Referred by* Internet website* Health Fair/Event* Yellow Pages* Met Doctor* Drove by
*Name: _____

Patient Information

Patient's First & Last Name: _____

Date of Birth: _____ Gender: Male Female Marital Status: single married widowed divorced

Address: _____ Apt/Suite#: _____ City: _____ State: _____ Zip: _____

Home Phone #: () _____ Cell/Pager/Other #: () _____

Email address: _____

Social Security #: _____ Driver's License #: _____

Emergency Contact Name: _____ Tel #: () _____

Relationship to Patient: _____

Address: _____ Apt/Suite#: _____ City: _____ State: _____ Zip: _____

Home Phone #: () _____ Cell/Pager/Other #: () _____

Work Phone #: () _____ Extension: _____ Email: _____

Patient Employment Information (CURRENT JOB)

Not employed Student Self-employed → Business Name: _____

Employer/School: _____ Occupation: _____

Address: _____ Apt/Suite#: _____ City: _____ State: _____ Zip: _____

Work Phone #: () _____ Extension: _____

Patient Health Insurance Information (CURRENT INSURANCE)

Do you currently have Health Insurance: No Yes → Complete below

Name of Insured/Subscriber: _____

Relationship: Self Spouse Child Parent Legal Guardian Other: _____

Insurance Company: _____

Plan Type: PPO HMO Medicare Other: _____

ID #: _____ Policy #: _____ Group #: _____

Insurance Tel # (on back of card): () _____

Name of Primary Care Doctor: _____ Tel #: () _____

Patient's Attorney Information

Have you hired an attorney: No Yes → Attorney First & Last Name: _____

Law Firm/Office Name: _____

Paralegal/Assistant's Name: _____

Address: _____ Suite#: _____ City: _____ State: _____ Zip: _____

Home Phone #: () _____ Cell/Pager/Other #: () _____

Work Phone #: () _____ Extension: _____

Fax: () _____ Email address: _____

Employer's Insurance Information for Workers Compensation

Name of Work. Comp. Insurance Company: _____
Address: _____ Suite#: _____ State: _____ Zip: _____
Claim#: _____ WCAB (Appeals Board Case) #: _____
Claims Adjuster Name (whom you spoke with): _____
Address to mail claim: _____ City: _____ State: _____
Tel.#: () _____ extension: _____ Fax.#: () _____
Name of M.D. who referred you: Dr. _____
Doctor's Office Tel#: () _____ Address: _____
Prescribed treatment plan (# visits per week): N Y → _____

A. Accident & Injury Information

1) EMPLOYMENT INFORMATION (AT TIME OF ACCIDENT)

Job Title (at time of injury): _____
Employer/Company name (at time of injury): _____
Nature of business (e.g.: school, police, manufacturing, construction, etc...): _____
Supervisor Name: _____
Supervisor Phone#: () _____ Extension: _____
Employer Address: _____
City: _____ State: _____ Zip: _____

2) ACCIDENT / INJURY DETAILS: Date: _____ Time: _____ AM/PM

Address: _____
Location/Place of Injury: _____
City: _____ State: _____ Zip: _____

Work Conditions/Environment: _____
Date injury reported to supervisor: _____
Date last worked [job at time of injury]: _____

- ▶ Have you received any AWARD for FUTURE MEDICAL CARE: N Y → _____
- ▶ Do you have a copy of this award letter: N Y → _____
- ▶ Are you now "PERMANENT & STATIONARY" ("P & S"): N Y → _____

Describe the accident in your own words using specific details:

Did you fill out an injury form at work or an "Employee Claim for Work Comp Benefits"? N Y
Did authorities/personnel arrive on scene: N Y → Was a written report created? N Y
Do you have a copy of any reports: N Y → _____

Did you speak to anybody or did anybody approach you: N Y → _____
Were photos taken of incident scene: N Y → Who took photos: _____
Were there any witnesses to the accident: N Y → Witness Names & Tel. numbers: _____

Were you in a vehicle that belonged to your company of employment (e.g. company car) at the time of injury? N Y → _____
Is there a Personal Injury claim also being filed? N Y → _____

B. Your Current Injuries & Symptoms due to Incident

1) **Please describe how you felt...[e.g. cuts, scrapes, bruises, pain, stiff, sore, emotions, etc..]**

IMMEDIATELY AFTER the incident: unconscious dizzy/dazed disoriented
nervous nauseous upset weak other: _____

LATER that day: _____

The NEXT day: _____

2) **CURRENT COMPLAINTS: Check ALL symptoms you have noticed since the incident:**

***Note Your Current Intensity of Pain (0=no pain through 10=constant severe pain).**

***CIRCLE R=right OR L=left OR BOTH**

- | | | | | |
|--|--|---|--|--|
| <input type="checkbox"/> *Head pain=___/10 | <input type="checkbox"/> jaw/TMJ pain | <input type="checkbox"/> impatient | <input type="checkbox"/> face flushed | <input type="checkbox"/> feet cold |
| <input type="checkbox"/> *Neck pain=___/10 | <input type="checkbox"/> chest pain | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> buzzing in ears | <input type="checkbox"/> hands cold |
| <input type="checkbox"/> *Upper back pain=___/10 | <input type="checkbox"/> eye pain | <input type="checkbox"/> coughing | <input type="checkbox"/> hiccups | <input type="checkbox"/> fever |
| <input type="checkbox"/> *Mid back pain=___/10 | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> tension | <input type="checkbox"/> grinding teeth | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> *Low back pain=___/10 | <input type="checkbox"/> jaw clenching | <input type="checkbox"/> irritability | <input type="checkbox"/> nervous | <input type="checkbox"/> restless |
| <input type="checkbox"/> *R/L Shoulder pain=___/10 | <input type="checkbox"/> dizziness | <input type="checkbox"/> fatigue | <input type="checkbox"/> loss of balance | <input type="checkbox"/> stomach upsets |
| <input type="checkbox"/> *R/L Elbow pain=___/10 | <input type="checkbox"/> head is "heavy" | <input type="checkbox"/> depression | <input type="checkbox"/> fainting | <input type="checkbox"/> constipation |
| <input type="checkbox"/> *R/L Wrist pain=___/10 | <input type="checkbox"/> mood swings | <input type="checkbox"/> light sensitivity | <input type="checkbox"/> loss of smell | <input type="checkbox"/> cold sweats |
| <input type="checkbox"/> *R/L Hip pain=___/10 | <input type="checkbox"/> disoriented | <input type="checkbox"/> loss of memory | <input type="checkbox"/> loss of taste | <input type="checkbox"/> hot sweats |
| <input type="checkbox"/> *R/L Knee pain=___/10 | <input type="checkbox"/> unconscious | <input type="checkbox"/> ringing in ears | <input type="checkbox"/> diarrhea | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> *R/L Ankle pain=___/10 | <input type="checkbox"/> headaches | <input type="checkbox"/> blurred vision | <input type="checkbox"/> confused | <input type="checkbox"/> difficulty sleeping |
| <input type="checkbox"/> *R/L Foot pain=___/10 | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> fear of driving/entering a vehicle | | |
| | <input type="checkbox"/> loss of concentration/difficult to focus on tasks | | | <input type="checkbox"/> nightmares |

Broken bones→regions: _____

Open cuts/Scrapes→regions: _____

Bruising (blue/red discoloration)→regions: _____

Muscle spasms→regions: _____

Muscle Weakness: →regions: _____

Numbness/Tingling/Pins & Needles:→regions: _____

Head pain that travels/radiates to: left side of head right side of head both sides of head
 front of head back of head top of head neck other: _____

Neck pain that travels/radiates to: left shoulder left arm left forearm left hand
 right shoulder right arm right forearm right hand other: _____

Low Back pain that travels/radiates to: left buttock left thigh left knee left foot
 right buttock right thigh right knee right foot other: _____

ANY OTHER SYMPTOMS: _____

3) **List any part of your body that struck any object/surface (eg: floor, table, chair, door, window, etc.):** _____

4) **Were you knocked unconscious:** No Yes→For how long: _____ minutes/hours/days not sure

5) **Since this injury occurred, are your symptoms:** getting worse no change improving

6) Where did you go RIGHT AFTER the accident? CHECK ALL THAT APPLY:

→ **HOSPITAL/URGENT CARE** OR → **DOCTOR'S OFFICE**

How did you get to the hospital/office: Ambulance Drove yourself Someone else drove you

Were you offered transportation via ambulance: No Yes → Reason why you declined ambulance:

too scared could not afford it no health insurance just wanted to go home

Other: _____

Hospital/Clinic Name: _____ Doctor's name: _____

X-rays/MRI/CT scans taken: Head Neck Back None Other: _____

All Diagnoses: _____

Treatment/Supports received: exam only stitches bandages neck collar crutches cane

Other: _____

All medications prescribed: "Pain killer" "Muscle relaxer" "Anti-Inflammatory" None

Other Medications: _____

Instructed to: Follow-up with primary doctor Get physical therapy Take prescribed medications

Read "Care for concussions" Read "Care for sprains-strains" Read "Care for work injury"

Other: _____

→ **HOME** - If you went home, did you treat yourself: No Yes → ice pack hot shower rest

"Over the counter" medications: Tylenol Motrin Aleve Aspirin Excedrin

Other: _____

How did you get home: Drove yourself Someone else drove you

→ **OTHER LOCATION** → Details: _____

7) As a result of this incident, have you seen any OTHER Doctor, Health Care Provider or Therapist:

URGENT CARE / AFTER HOURS CLINIC → Date(s): _____

DOCTOR / PROVIDER OFFICE → Date(s): _____

Clinic name: _____ Doctor/Provider name: _____

Area of Specialty/Type of Provider: Medical Doctor Primary Care Dr Orthopedic surgeon

Pain Management Dr Chiropractor Acupuncturist Physical therapist Massage therapist

Other: _____

All Diagnoses: _____

X-rays/MRI/CT scans taken: None Head Neck Back Other: _____

Treatment received: Exam only Surgery Stitches Bandages Injections

Other: _____

All medications prescribed: "pain killer" "muscle relaxer" "anti-inflammatory" none

Other Medications: _____

Instructed to: Follow-up with primary doctor Get physical therapy Take prescribed medications

Rest No instructions given Other: _____

8) Any other treatment received for this condition: No Yes → Date(s) of treatment _____

Treatment Details: _____

9) IF YOU DID NOT SEE A DOCTOR WITHIN THE FIRST FEW WEEKS, DESCRIBE WHY:

no transportation no appointment available could not afford care no pain was noticed

work/home schedule conflicts required to work to pay rent/bills no health insurance

I thought pain/symptoms would "go away"

Other: _____

C. Your Daily Activities at Home/Work/School

1) Since this injury, have you lost time from work/school: No Yes → List dates missed: _____

Last day worked: Date of Incident Other date: _____

Current salary: \$_____ per hour/week/month/year Tips (Avge per day): \$_____

Total amount of lost pay to date: \$ _____

Are you being compensated for time lost from work: No Yes→

If YES, type of compensation you are receiving: _____

2) Are you currently working?

No → Are you: looking for employment "stay at home" parent other: _____

Yes → Are you on: regular duty light duty part time other: _____

Are you currently a student? Yes → Are you taking classes: full time part time

other: _____

3) Do you notice any activities that are difficult to do at WORK / SCHOOL as a result of this injury?

No Yes → Details: _____

4) Do you notice any activities that are difficult to do at HOME as a result of this injury?

No Yes → Details: _____

5) Since the incident, do you have more difficulty at home with raising children? N/A No Yes→

Kids _____ → List Ages: _____

6) Do you require assistance from another family member/friend or hired help/nanny?

No Yes→Details: _____

7) Since the incident, are there any activities that you are now no longer able to enjoy OR have difficulty doing due to incident (e.g. hobbies, sports, domestic duties, household duties, etc....)?

No Yes→Details: _____

D. Current Health Status

1) What makes your condition worse: sitting standing walking bending forward

lying down on back Other: _____

2) What makes your condition better: ice pack hot shower rest standing lying on back

Medications→ _____

Other: _____

3) Describe the quality of your pain/condition: sharp dull achy burning throbbing

Other quality: _____

4) What percent of the time do you have your pain / condition (% of day):

constant [100%] frequent [75%] intermittent [50%] occasional [25%]

E. Previous Medical History [NOT relating to current injury/incident]

1) Current Age: _____ Height: feet= _____ inches= _____ Weight: _____ pounds

2) Date of Last Medical Exam/Physical: _____ don't recall

Doctor/Office Name: _____

3) Results/Findings/Diagnoses: _____

4) Results of Blood/Lab Tests: _____

5) Results of X-rays/CT/MRI: _____

6) Other Tests: _____

7) For Women: Is there any chance you may be pregnant: No Yes→# weeks:

- 8) All Prescribed Medications: _____
- 9) All Over-The-Counter Medications: _____
- 10) Do you have any congenital (from birth) factors which relate to your condition:
 No Yes → details/dates: _____
- 11) Do you have any previous illnesses/complications from previous injuries:
 No Yes → details/dates: _____
- 12) Have you ever been involved in any accident in the last 10 years: No Yes → details/dates: _____

Treatment Received for previous injuries: None Yes → details: _____

Any residual pain/symptoms/complications from previous injuries: None Yes → details: _____

13) Did you have any physical complaints before this incident: No Yes → _____

14) Have you ever been to the hospital for any reason (surgery, trauma, childhood, etc.):
 No Yes → details/dates: _____

EXCLUDING injuries from this accident, have you EVER had injuries to any of the following regions? Please state RIGHT/LEFT side, details, dates, any complications, healed/resolved:

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Head _____	<input type="checkbox"/>	<input type="checkbox"/>	Hip [R or L] _____
<input type="checkbox"/>	<input type="checkbox"/>	Neck _____	<input type="checkbox"/>	<input type="checkbox"/>	Knee [R or L] _____
<input type="checkbox"/>	<input type="checkbox"/>	Spine _____	<input type="checkbox"/>	<input type="checkbox"/>	Thigh [R or L] _____
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder [R or L] _____	<input type="checkbox"/>	<input type="checkbox"/>	Calf [R or L] _____
<input type="checkbox"/>	<input type="checkbox"/>	Elbow [R or L] _____	<input type="checkbox"/>	<input type="checkbox"/>	Ankle [R or L] _____
<input type="checkbox"/>	<input type="checkbox"/>	Wrist [R or L] _____	<input type="checkbox"/>	<input type="checkbox"/>	Foot [R or L] _____
<input type="checkbox"/>	<input type="checkbox"/>	Hand [R or L] _____	<input type="checkbox"/>	<input type="checkbox"/>	Toes [R or L] _____
<input type="checkbox"/>	<input type="checkbox"/>	Fingers [R or L] _____	<input type="checkbox"/>	<input type="checkbox"/>	OTHER _____

**F. Previous Medical Concerns [NOT relating to current injury/incident]
 Check ALL of the following that apply to you.**

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Loss of consciousness/head injuries	<input type="checkbox"/>	<input type="checkbox"/>	Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Visual disturbances/Eye problems	<input type="checkbox"/>	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	<input type="checkbox"/>	Nose, throat, breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	Asthma, allergies, allergic reactions	<input type="checkbox"/>	<input type="checkbox"/>	Sleep apnea/sleep conditions
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea, constipation	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems
<input type="checkbox"/>	<input type="checkbox"/>	Numbness in groin/buttocks	<input type="checkbox"/>	<input type="checkbox"/>	Urinary problems
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal/rapid weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	Recent fever
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Corticosteroid - cortisone, prednisone
<input type="checkbox"/>	<input type="checkbox"/>	Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Birth control pills
<input type="checkbox"/>	<input type="checkbox"/>	Pain at night	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol/tobacco/drug abuse
<input type="checkbox"/>	<input type="checkbox"/>	Pain unrelieved by position/rest	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Morning pain/stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Blood disease: _____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer/tumor/lumps: _____			
<input type="checkbox"/>	<input type="checkbox"/>	Stroke [date/complications]: _____			

Any Organ Problems/Diseases: Heart Liver Kidney Stomach Pancreas Gall bladder
 Lungs Intestines Prostate Uterus Ovaries Thyroid Other: _____