**EMPLOYEE INFORMATION**

Name : _____ SSN : _____

DOB/ Age : _____

Address : _____

Phone No. : (home)_____ (cell/office) _____

Male __ Female ___ Right Handed ___ Left Handed __ Both __ Height ____ Weight ___

**EMPLOYER INFORMATION**

Name of Business : _____

Address : _____ Phone # : _____

**WORKER'S COMPENSATION INSURANCE CARRIER INFORMATION :**

Name : _____ Phone # : _____

Address : _____

Claim Representative : _____ Fax # : _____

Claim # : _____

**INFORMATION ABOUT YOUR WORK INJURY :**

Date of Injury : _____ Time the Injury Occurred : _____ A.M./P.M.
Date You Reported Your Injury to Your Employer/Supervisor : _____
Name Of Person You Reported Your Injury To : _____
Where Did Your Injury Occur? (Address or Description Of Location) : _____
_____

**ATTORNEY INFORMATION : (  ) CHECK IF NONE**

Name : _____ Phone # : _____
Address : _____

## HISTORY OF THE INJURY

Please briefly describe how your work injury occurred :

Please briefly describe the symptoms arising from your injury :

How did your symptoms come on? ___ Suddenly ___ Gradually . If gradually, over what period of time? _____

When did you realize/know that you were injured? Explain: _____

## HISTORY OF TREATMENT :

When did you first seek treatment for your injury? Date : _____
Did your employer send you for treatment? ____ Yes ____ No
Did You Seek Treatment On Your Own? ____ Yes ____ No
**'INITIALLY' , did you go to a Hospital/Emergency Room?** ____ Yes ____ No
(**If 'Yes'**, Answer The Questions Below. **If 'No"**, Go To The Name Of Doctor/Facility #1 On This Page)
Name Of Hospital/ER : _____
Were you admitted to the hospital? ___ Yes ____ No, If 'Yes', how long? _____
Name Of Doctor(s) at the hospital who treated you? _____
Describe the type of treatment, diagnosis or testing that was done : _____

What did the hospital doctor (s) ay was wrong with you? _____

Were you told that you would need more treatment? ___ Yes ___ No , If 'Yes' explain:

Did The doctor(s) restrict or modify your work activities? ___ Yes ___ No, if 'Yes', how?

(History Of Treatment - Continued)

Please list **ALL** doctors you have seen regarding your work injury. Please list them in chronological order/ **The Order You Saw Them In** :

**Name of Doctor/facility #1** : _____ City/ Location: _____
Type Of doctor (degree/specialty): _____
Describe treatment and/or tests: _____
What did the doctor say was wrong with you? _____
Date when treatment started: _____ Date when treatment stopped: _____
How many treatments/visits were there? _____ How long were the treatments? _____ What was the result/outcome of the treatment? _____
Still treating with this doctor? ___ Yes ___ No If 'Yes' how often? _____
Did this doctor take you off work? ___ Yes ___ No. If 'yes' give dates: _____
Did this doctor restrict or modify your work activities? ___ Yes ___ No. If 'Yes' how?
Did this doctor say you would need more treatment? ___ Yes ___ No. If 'Yes', explain:
Did this doctor refer you anywhere else? ___ Yes ___ No. If 'Yes', where and why?

**Name of Doctor/facility #2** : _____ City /Location: _____
Type of doctor (degree/specialty): _____
Describe treatment and/or tests: _____
What did the doctor say was wrong with you? _____
Date when treatment started: _____ Date when treatment stopped: _____
How many treatments/visits were there? _____ How long were the treatments? _____ What was the result/outcome of the treatment? _____
Still treating with this doctor? ___ Yes ___ No. If 'Yes' how often? _____
Did this doctor take you off work? ___ Yes ___ No. If 'Yes' Give dates: _____
Did this doctor restrict or modify your work activities? ___ Yes ___ No. If 'Yes' how?
Did this doctor say you would need more treatment? ___ Yes ___ No. If 'Yes', explain:

(History Of Treatment - Continued)

Did this doctor refer you anywhere else? ___ Yes ___ No. If 'Yes', where and why?

_____

_____

_____

**Name of Doctor/facility #3** : _____ City/Location: _____

Type of doctor (degree/specialty): _____

Describe treatment and/or tests: _____

_____

What did the doctor say was wrong with you? _____

_____

Date When Treatment Started: _____ Date When Treatment Stopped: _____

How Many Treatments/Visits Were There? _____ How Long Were The Treatments? _____ What Was The Result/Outcome Of The Treatment? _____

_____

Still Treating With This Doctor? ___ Yes ___ No if 'Yes' How Often? _____

Did This Doctor Take You Off Work? ___ Yes ___ No, if 'Yes' Give Dates: _____

_____

Did This Doctor Restrict Or Modify Your Work Activities? ___ Yes ___ No, if 'Yes' How? _____

Did This Doctor Say You Would Need More Treatment? ___ Yes ___ No, if 'Yes', explain: _____

Did This Doctor Refer You Anywhere Else? ___ Yes ___ No, if 'Yes', Where And Why?

_____

Were any other tests, examinations, treatments or therapy done that were not described above? ___ Yes ___ No. If 'Yes', please describe what was done and what the results were? (use back page if necessary): _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you treat yourself? ___ Yes ___ No. If 'Yes', Please explain how : _____

_____

_____

(History Of Treatment - Continued)

Are you currently taking medication to relieve the effects of the injury?
___ Yes ___ No. If 'Yes', please describe what you take, (prescription or non-prescription), how much it helps, how often you take it, etc. : ____ _____

Have there been any recommendation for diagnostic testing or treatment that you have not received? ___ Yes ___ No. If 'Yes' , what was recommended and who recommended it?

## HISTORY OF OTHER INJURIES

Have you ever experienced the same or similar symptoms/problems ***BEFORE*** this work injury? ___ Yes ___ No. If 'Yes', please explain in detail : _____ _____

Have you ever had a ***PRIOR*** work injury(ies)? ___ Yes ___ No. If 'Yes', please explain:

Have you ever received a ***PRIOR*** worker's compensation disability award?
___ Yes ___ No. If 'Yes', please explain: _____

Have you ever served in the **Military**? ___ Yes ___ No. If 'Yes', Did you receive a medical discharge? ___ Yes ___ No. If 'Yes', please explain why? _____

(History Of Other Injuries - Continued)

Have you ever had any ***PRIOR,*** **NON-WORK RELATED PSYCHIATRIC CONDITIONS?** ____ Yes ___ No. If 'Yes', please explain: _____

## CURRENT SYMPTOMS

**Please list your CURRENT symptoms/complaints resulting FROM YOUR WORK INJURY:**

**Complaint #1** : _____

What percentage of the time do you experience/feel this symptom? _____%

What activities make this symptom worse?_____

What makes this symptom better? _____

Can/do you have this symptom without activity? _____

Pain Scale : _____ 0 - 10

**Complaint #2** : _____

What percentage of the time do you experience/feel this symptom? _____%

What activities make this symptom worse?_____

What makes this symptom better? _____

Can/do you have this symptom without activity? _____

Pain Scale : _____ 0 - 10

**Complaint #3** : _____

What percentage of the time do you experience/feel this symptom? _____%

What activities make this symptom worse?_____

(Current Symptoms - Continued)

What makes this symptom better? _____

Can/do you have this symptom without activity? _____

Pain Scale : _____ 0 - 10

**Complaint #4** : _____
What percentage of the time do you experience/feel this symptom? _____%
What activities make this symptom worse?_____

What Make This Symptom Better? _____

Can/do you have this symptom without activity? _____

Pain Scale : _____ 0 - 10

Is There A Time Of Day That You Feel Worse? ___ Yes ___ No, if 'Yes' , Please Explain: _____

In the last ***Two Months***, has your condition ____ stayed the same ____ improved _____ worsened _____ fluctuated, but overall has stayed about the same?
If your condition has ***Worsened,*** please explain: _____

If your condition ***Continues To Improve***, please explain: _____

Do you feel that your condition will improve with time? ___ Yes ___ No,
please explain: _____

Before this work injury, how would you describe your health?
___ Excellent ___ Good ___ Fair ___ Poor,
If 'Fair' or 'Poor', please explain: _____

## JOB DESCRIPTION

What is your job title? (AT THE TIME OF YOUR INJURY): ___
Describe the nature of your work: _____
When did you start working for this employer? _____
How many hours per day do you normally work? _____
What hours do you normally work? _____
How many days per week do you work?_____ How many days in a row? _____
How many rests breaks do you get in a normal work shift?_____
What percent of your work day do you work indoors? _____% outside _____%

(Job Description - Continued)

**Please List Your Job Duties/Activities At Work (AT THE TIME YOU WERE INJURED):**

A). _____
B). _____
C). _____
D). _____
E). _____
F). _____
G). _____

Are you exposed to dust, gas, fumes, vapors, noise, or extreme temperature or humidity? ___ Yes ___ No. If 'Yes' , please explain : _____

Do you have any special visual/hearing or other requirements? ___ Yes ___ No If 'Yes' , please describe: _____

## WORK HISTORY

Do you have **More Than One Employer At The Time You Were Injured?**
___ Yes ___ No. If 'Yes', lease list the employer(s), and the activities at that employment? _____

**If 'Yes'**, did the other employment/activities listed above **Contribute to, Or Further Worsen Your Condition?** ___ Yes ___ No If 'Yes', please explain how?

(Work History - Continued)

Please list all of **Your Previous Employers** : (i.e. where you have worked before the job where your current injury occurred)

| | **Employer** | **Date Of Employment** | **Job Title** |
|---|---|---|---|
| A) | | | |
| B) | | | |
| C) | | | |
| D) | | | |
| E) | | | |
| F) | | | |
| G) | | | |

Are you still working for the *Same Employer*, where your work injury occurred?
___ Yes ___ No, **if 'No'**, Please Answer The Questions Below. If **'Yes'** , please skip the following questions and go to the next section entitled **' MEDICAL HISTORY'.**
Why aren't you working for the same employer now? _____

When did you stop working for the same employer? Date:_____

If you are not working for the same employer as when you were injured, **Please List Your Employment Since Leaving:** or _____ I have not worked since leaving that employment.

| | **Employer** | **Date Of Employment** | **Job Title** |
|---|---|---|---|
| A) | | | |
| B) | | | |
| C) | | | |
| D) | | | |
| E) | | | |
| F) | | | |
| G) | | | |

Who is your current employer(s)? _____

Are you doing the same type of work? ___ Yes ___ No.
If 'No', please describe the type of work you are doing now, including details on physical
(Work History - Continued)

activity : _____

Has any **NEW** job or employment **Contributed To, Or Further Worsened Your Condition?** ____ Yes ___ No. If ' Yes', please name the employer(s) and explain how?

Are you going to be **Retrained For Another Job Occupation** as a result of this work injury? ____ Yes ___ No ___ I do not know ____ recommended, please describe:

## MEDICAL HISTORY

Please list information about your medical history in the section below, with the approximate dates. If a section does not apply to you, simply mark an "X", in the 'Denied' Box:

Childhood Illnesses: ( ) Denied _____

Childhood Injuries: ( ) Denied _____

Allergies: ( ) Denied _____

Present Medications taken (prescription & over the-counter): ( ) Denied _____

Surgeries: ( ) Denied _____

Hospitalizations: ( ) Denied _____

Adult Illnesses: ( ) Denied _____

## FAMILY MEDICAL HISTORY

List Any Health Problems In **Your Immediate Family (Mother, Father, Brother, Sister):** ( ) Denied _____

## REVIEW OF SYSTEMS

Please List Any Problems That You Now have With The Following Body Systems:

Ear/Nose/Throat: ( ) Denied _____
Eyes: ( ) Denied _____
Lungs: ( ) Denied _____
Liver: ( ) Denied _____
G-I Tract (Stomach, Intestines, Bowels, etc.): ( ) Denied _____
Kidney/Bladder: ( ) Denied _____
(Women) Reproductive System: ( ) Denied _____
Skin: ( ) Denied _____
Neurological: ( ) Denied _____
Heart/Circulation: ( ) Denied _____

## OFF WORK ACTIVITIES

Do You Exercise? ___ Yes ___ No. **If 'Yes'** , please describe type and frequency. **If 'No'** , please explain why you don't : _____

Do you participate in any sport activities? ___ Yes ___ No. If 'Yes', please describe type and frequency: _____

Do you have any hobbies? Yes No. If 'Yes', Please describe type and frequency: _____

Are you able to perform your normal/regular household chores/activities? ___ Yes

_____ No. If 'No", please explain what you can not do and why? _____

## SOCIAL HISTORY

Are You? ( ) Married ( ) Single ( ) Separated ( ) Divorced ( ) Widowed
Prior marriages? Yes___, No ___, If "Yes", dates:_____.
How many years of education do you have? _____
List degrees, diplomas, licenses, certifications you hold: _____

Do you use alcohol? ___ Yes ___ No If ' Yes', how many drinks per week? _____
Do you use tobacco? ___ Yes ___ No. If 'Yes', what kind & times per day or week?

Do you use illicit drugs? ____ Yes ___ No. If 'Yes' , what kind & how many times per day or per week? _____

Thank You For Your Time Completing This Questionnaire.
Please Sign Below.
Injured Worker's Signature: _____Date: _____