

WORK/COMP QUESTIONNAIRE

Name: _____ Date of Accident: _____

1. Name of employer at time of accident: _____

2. Length of time worked there prior to accident: _____

3. Type of work being done at time of injury: _____

4. In your own words, please describe accident: _____

5. Have you been treated by another doctor for this accident? Yes No

6. Are you: () improved () unchanged () getting worse

7. What types of medicines are you taking? _____

Do these medicines help? () Yes () No

8. 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 _____

9. 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): _____

10. Have you had any other serious accidents which required medical care? () Yes () No

Describe: _____

11. Have you had any serious illnesses that required hospitalization? () Yes () No

Describe: _____

12. Have you had any surgeries? () Yes () No

If yes, list type of surgery and date: _____

13. Have you had any nervous or mental illnesses? () Yes () No

Have you had psychiatric care? () Yes () No

14. Have you received a medical discharge from the Armed Forces? () Yes () No

15. Have you returned to work since this accident? () Yes () No

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: () () all of the time
4. My pain goes into my: () () left leg () both
5. I have tingling and/or numbness in my: () () 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: () Yes () No

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	OCASIONALLY	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?

Describe:

8. Are you required to be around moving machinery?

Describe:

9. Are you exposed to marked changes in temperature and humidity?

Describe:

10. Are you required to drive automotive equipment?

Describe:

11. Are you exposed to dust, fumes and/or gases?

Describe:

12. Please list any additional comments:

Describe:

13. Attorney name, address and telephone number and fax number / Involved employer

Attorney name, address, telephone#, fax#

Involved employer name, address, telephone#, fax#
