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# 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

   If yes, please list doctor's name and address: _____

   _____

   What type of treatment did you receive? _____

   How long were you treated by this doctor? _____
6. Are you: ( ) improved ( ) unchanged ( ) getting worse
7. What types of medicines are you taking? _____

   _____

   Do these medicines help? ( ) Yes ( ) No ( ) Don't know
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 _____

   Does the physical therapy help? ( ) Yes ( ) No ( ) Don't know
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

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

**NECK PAIN** (continued):

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/or gases? ( ) Yes ( ) No

Describe: _____

_____

_____

12. Please list any additional comments: _____

_____

_____

_____

_____

Signature: _____ Date: _____