

Worker's Compensation Questionnaire

Please complete all of the following questions regarding your accident. These details are very important, and the doctor will use them with his examination and final care plan.

Claim Number _____
Full name _____ Today's date _____
Name of employer/company _____
Address _____
Phone number _____
Supervisor's name _____

When did the injury occur? Date _____ Time _____
Where did the injury occur? _____

Explain the accident in your own words _____

Did you inform your employer of the injury within 48 hours? Yes No If No, why? _____

1. **My accident was due to** (check ALL that apply): Slip Trip Stumble Fall Overtime
Not my regular job activity Other _____

2. **After the accident, when did your symptoms begin?** Immediately Couple of hours later
Half a day later The next day 2 days later Other _____

3. **How has your pain progressed since the accident?** Worse Same Improved

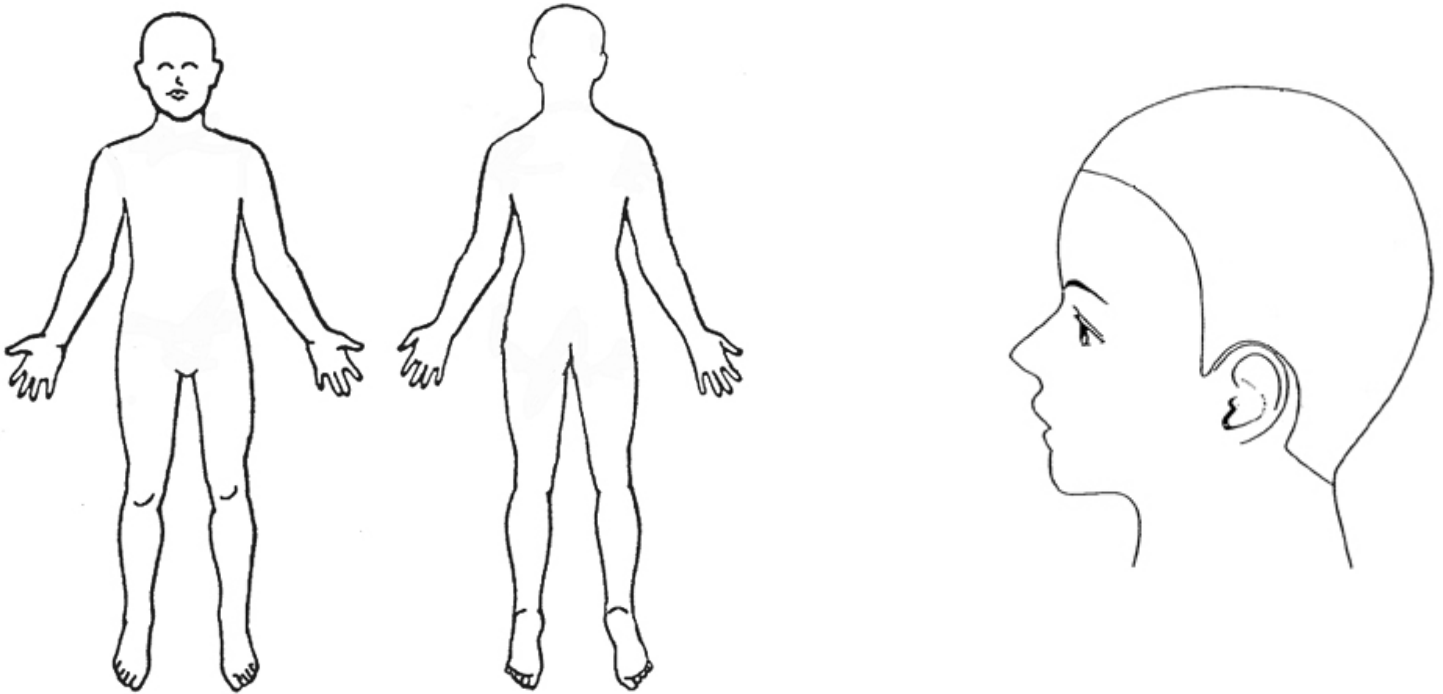
4. **List any work limitations since the injury** _____

5. **Do any other diseases or accidents affect your employment?** Yes No
If Yes, explain _____

6. **In your work, do you use any part of your body more than others?** (eg, repeatedly pulling a lever with your right hand) Yes No If Yes, explain _____

7. List any limitations on your daily activities since the injury (eg, pain with sitting, can't wash hair) _____

8. On the picture below, please mark an X over ANY area(s) that ARE or WERE painful



9. Were you seen at a hospital? Yes No If Yes, how many hours after the accident? _____

Hospital name _____

Were X-rays taken? Yes No _____

Medications prescribed at the hospital: Muscle relaxant Anti-inflammatory Painkiller

Other medication(s) _____

Time off from work given? Yes No If Yes, from _____ to _____

10. Please list any other doctors/healthcare providers seen since the accident/injury

A. Name _____ Address _____

Phone _____

Tests or treatment given _____

B. Name _____ Address _____

Phone _____

Tests or treatment given _____

11. Previous accidents or significant injuries to areas injured in this accident

A. Type of accident _____ Date _____

Area(s) injured _____

Did you recover completely? Yes No If No, explain _____

B. Type of accident _____ Date _____

Area(s) injured _____

Did you recover completely? Yes No If No, explain _____

