



WORKER'S COMPENSATION - PATIENT HISTORY

PLEASE PRINT:

NAME: _____ DATE: _____

EMPLOYER'S BUSINESS NAME AT TIME OF ACCIDENT: _____

EMPLOYER'S PHONE: _____ EMPLOYER'S ADDRESS: _____

OCCUPATION: _____

YES NO PREVIOUS WORKER'S COMPENSATION INJURY? IMPAIRMENT RATING: _____

LENGTH OF TIME AT THIS JOB PRIOR TO INJURY: _____

DATE OF INJURY: _____ TIME OF INJURY: _____ LAST DATE WORKED: _____

WHAT WERE YOU DOING AT THE TIME YOU WERE INJURED? HOW DID THE ACCIDENT/INJURY HAPPEN? (LIFTING, BENDING, WALKING, CARRYING, STANDING, ETC.) _____

WHEN DID THE PAIN BEGIN? WHERE DID YOU FIRST FEEL IT? WAS THE PAIN INTENSE AT FIRST OR DID IT GRADUALLY WORSEN? PLEASE BE SPECIFIC: _____



REPORT ACCIDENT/ACCIDENT OBSERVER

WHAT DATE DID YOU REPORT THIS INJURY ON? _____

WHO DID YOU REPORT THIS INJURY TO? _____

WHAT IS HIS/HER POSITION? _____

YES NO DID ANYONE OBSERVE THIS ACCIDENT/INJURY?

IF YES, NAME: _____

POSITION: _____



SYMPTOMS FROM ACCIDENT

YES NO DID YOU RECEIVE BLEEDING CUTS OR BRUISES? IF CUTS, WHERE? _____
IF BRUISES, WHERE? _____

PLEASE DESCRIBE HOW YOU FELT. PLEASE BE SPECIFIC.

IMMEDIATELY AFTER THE ACCIDENT: _____

LATER THAT DAY NIGHT: _____

THE NEXT DAY(S): _____

- CHECK SYMPTOMS THAT HAVE BECOME APPARENT SINCE THE ACCIDENT/INJURY:
- | | | | |
|---|--|---|--|
| 1. <input type="checkbox"/> NERVOUSNESS | 11. <input type="checkbox"/> LOSS OF BALANCE | 21. <input type="checkbox"/> SLEEPING TROUBLE | 32. <input type="checkbox"/> HEADACHE |
| 2. <input type="checkbox"/> NECK PAIN/STIFFNESS | 12. <input type="checkbox"/> LOSS OF SMELL | 22. <input type="checkbox"/> TOE NUMBNESS | 33. <input type="checkbox"/> FAINTING |
| 3. <input type="checkbox"/> MIDBACK PAIN | 13. <input type="checkbox"/> LOSS OF TASTE | 23. <input type="checkbox"/> FINGER NUMBNESS | 34. <input type="checkbox"/> ANXIETY |
| 4. <input type="checkbox"/> LOW BACK PAIN | 14. <input type="checkbox"/> LOSS OF MEMORY | 24. <input type="checkbox"/> COLD HANDS | 35. <input type="checkbox"/> SEIZURES |
| 5. <input type="checkbox"/> EYES SENSITIVE TO LIGHT | 15. <input type="checkbox"/> PINS & NEEDLES - ARMS | 25. <input type="checkbox"/> COLD FEET | 36. <input type="checkbox"/> VISUAL DISTURBANCES |
| 6. <input type="checkbox"/> PAIN BEHIND EYES | 16. <input type="checkbox"/> PINS & NEEDLES - LEGS | 26. <input type="checkbox"/> CHEST PAIN | 37. <input type="checkbox"/> FORGETFULNESS |
| 7. <input type="checkbox"/> DIZZINESS | 17. <input type="checkbox"/> SHORTNESS OF BREATH | 27. <input type="checkbox"/> CONSTIPATION | 38. <input type="checkbox"/> BLURRED VISION |
| 8. <input type="checkbox"/> COLD SWEATS | 18. <input type="checkbox"/> HEAD SEEMS TOO HEAVY | 28. <input type="checkbox"/> DIARRHEA | 39. <input type="checkbox"/> DOUBLE VISION |
| 9. <input type="checkbox"/> FACE FLUSHED | 19. <input type="checkbox"/> IRRITABILITY | 29. <input type="checkbox"/> FATIGUE | 40. <input type="checkbox"/> CONFUSED |
| 10. <input type="checkbox"/> RINGING/BUZZING EARS | 20. <input type="checkbox"/> DEPRESSION | 30. <input type="checkbox"/> TENSION | 41. <input type="checkbox"/> DISORIENTED |
| | | 31. <input type="checkbox"/> FEVER | 42. <input type="checkbox"/> OTHER _____ |



MECHANISM OF INJURY

PLEASE EXPLAIN THE MECHANISM OF THE INJURY (ONLY FILL IN THOSE SECTIONS THAT APPLY TO YOU):

FALL:

A) YES NO DID YOU HIT ANYTHING WHEN YOU FELL? IF YES, WHAT? _____

B) YES NO WERE YOU CARRYING ANYTHING WHEN YOU FELL? IF YES, WHAT? _____
HOW MUCH DID IT WEIGH? _____ LBS.

C) YES NO DID YOU TWIST WHEN YOU FELL? IF SO, TO WHICH SIDE? LEFT RIGHT
 YES NO DID IT LAND ON YOU? IF YES, WHERE? _____

D) YES NO WAS THE AREA LIGHTED? _____

E) DESCRIBE THE CONDITION OF THE AREA (SLIPPERY, GRAVELED, ETC.) _____

F) WHAT PART OF THE BODY DID YOU FALL ON? _____

G) HOW FAR DID YOU FALL? (FT.) _____

H) WHAT DID YOU LAND ON? _____

LIFT/PULL:

- A) HOW MUCH DID THE OBJECT WEIGH? _____ LBS.
- B) YES NO DID YOU FALL AFTER THE INJURY? IF YES, HOW FAR? _____
 YES NO DID YOU HIT ANYTHING WHEN YOU FELL? WHAT? _____
- C) YES NO WERE YOU TWISTING WHEN YOU WERE LIFTING/PULLING? IF YES, TO WHICH SIDE? LEFT RIGHT
- D) HOW FAR OFF THE GROUND DID YOU HAVE THE OBJECT BEFORE THE PAIN STARTED? _____
- E) YES NO DID YOU DROP THE OBJECT WHEN THE PAIN STARTED?
 YES NO DID IT LAND ON YOU? WHERE? _____
- F) DID YOU LIFT WITH YOUR LEGS BACK OTHER _____

BEND:

- A) YES NO WERE YOU LIFTING WHEN YOU WERE BENT OVER? IF YES, HOW MUCH DID THE OBJECT WEIGH? _____ LBS.
- B) HOW FAR WERE YOU BENT OVER? _____
- C) YES NO DID YOU FALL WHEN THE PAIN STARTED? HOW FAR? _____
- D) YES NO WERE YOU TWISTING WHEN YOU BENT FORWARD? TOWARD WHICH SIDE? LEFT RIGHT
- E) YES NO DID YOU LAND ON ANYTHING? IF SO, WHAT _____



WORK STATUS HISTORY

- YES NO HAVE YOU LOST TIME FROM WORK AS A RESULT OF THIS NEW INJURY?
IF YES, DATES: _____
- YES NO HAVE YOU GONE BACK TO WORK? WHEN: _____
IF YES, WHAT STATUS OF WORK: MODIFIED REGULAR
LIST RESTRICTIONS YOU HAVE BEEN PLACED ON: _____
IF YOU HAVE GONE BACK TO WORK, LIST ACTIVITIES THAT ARE:
PAINFUL: _____
DIFFICULT: _____
- YES NO IF YOU ARE CURRENTLY ON DISABILITY (TIME LOSS), DO YOU WANT TO GO BACK TO WORK DOING YOUR REGULAR JOB?
IF NO, WHY NOT? _____
- YES NO ARE THERE ANY PROBLEMS YOU HAVE WITH A FELLOW EMPLOYEE, SUPERVISOR, OR MANAGER THAT NEEDS TO BE DISCUSSED? IF YES, EXPLAIN: _____



FIRST DOCTOR/HOSPITAL/CLINIC

- YES NO WERE YOU HOSPITALIZED AS A RESULT OF THIS ACCIDENT? IF YES, WHERE: _____
DOCTOR 1 NAME: _____ DATE OF FIRST VISIT: _____
- YES NO WERE YOU EXAMINED? YES NO WERE X-RAYS TAKEN?
WHAT DIAGNOSIS DID THE DOCTOR GIVE YOU? _____
- YES NO WERE YOU GIVEN TREATMENT? IF YES, WHAT TYPE? _____
WHAT BENEFITS DID YOU RECEIVE FROM THIS TREATMENT? _____
DATE OF LAST TREATMENT: _____
- YES NO DID THE DOCTOR REFER YOU TO ANOTHER HEALTH PROFESSIONAL? IF YES, TO WHOM AND FOR WHAT? _____
- YES NO DID YOU FOLLOW THE DOCTOR'S RECOMMENDATION? IF NO, WHY NOT? _____



SECOND DOCTOR/CLINIC

- DOCTOR 2 NAME: _____ DATE OF FIRST VISIT: _____
- YES NO WERE YOU EXAMINED? YES NO WERE X-RAYS TAKEN?
- YES NO WERE YOU GIVEN TREATMENT? IF YES, WHAT TYPE? _____
WHAT BENEFITS DID YOU RECEIVE FROM THIS TREATMENT? _____
DATE OF LAST TREATMENT: _____



PRIOR SIMILAR SYMPTOMS

- YES NO DID YOU HAVE ANY PHYSICAL COMPLAINTS JUST BEFORE THE ACCIDENT? IF YES, PLEASE DESCRIBE IN DETAIL: _____
- YES NO HAVE YOU EVER HAD ANY PRIOR INJURIES, ACCIDENTS, DISEASES OR TREATMENT TO THE AREA OF YOUR BODY NOW AFFECTED?
IF YES, WHAT PART WAS PREVIOUSLY INJURED? _____
DATE HURT: _____ DESCRIBE INJURY: _____
- YES NO WERE YOU TREATED? BY WHOM? _____
DATE TREATMENT BEGAN: _____ ENDED: _____
THE LAST DATE YOU FELT PAIN OR PROBLEMS FROM THAT INJURY: _____



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.

IN A TYPICAL 8-HOUR WORKDAY, I (CIRCLE THE NUMBER OF HOURS OF 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 |

ON THE JOB, I PERFORM THE FOLLOWING ACTIVITIES:

| | NOT AT ALL | OCCASIONALLY | FREQUENTLY | CONTINUOUSLY |
|----------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| BEND/STOOP | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| SQUAT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| CRAWL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| CLIMB | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| REACH ABOVE SHOULDER LEVEL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| CROUCH | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| KNEEL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| BALANCING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| PULLING/PUSHING | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| ON THE JOB, I LIFT: | NOT AT ALL | OCCASIONALLY | FREQUENTLY | CONTINUOUSLY |
|---------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| UP TO 10 POUNDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11 TO 24 POUNDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25 TO 34 POUNDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 35 TO 50 POUNDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 51 TO 74 POUNDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 75 TO 100 POUNDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- YES NO DO YOU HAVE TO BEND OVER WHILE DOING ANY LIFTING?
- YES NO ARE YOUR FEET USED IN REPETITIVE MOVEMENTS, SUCH AS OPERATING FOOT CONTROLS?
- DO YOU USE YOUR HANDS FOR REPETITIVE ACTIONS SUCH AS:

| | SIMPLE GRASPING | | FIRM GRASPING | | FINE MANIPULATING | |
|------------|------------------------------|-----------------------------|------------------------------|-----------------------------|------------------------------|-----------------------------|
| RIGHT HAND | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| LEFT HAND | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

- YES NO ARE YOU REQUIRED TO WORK AT UNPROTECTED HEIGHTS? IF YES, DESCRIBE: _____
- YES NO ARE YOU REQUIRED TO BE AROUND MOVING MACHINERY? IF YES, DESCRIBE: _____
- YES NO ARE YOU EXPOSED TO MARKED CHANGES IN TEMPERATURE AND HUMIDITY? IF YES, DESCRIBE: _____
- YES NO ARE YOU REQUIRED TO DRIVE AUTOMOTIVE EQUIPMENT? IF YES, DESCRIBE: _____
- YES NO ARE YOU EXPOSED TO DUST, FUMES, AND/OR GASES? IF YES, DESCRIBE: _____
- YES NO PLEASE LIST ANY ADDITIONAL COMMENTS: _____
- _____
- _____
- _____

SIGNATURE: _____ DATE: _____