Work-Related Injury Questionnaire

Please PRINT CLEARLY - All information is required & kept confidential.

Please provide us with your: • **Work Comp Insurance info** • **Health Insurance cards** • **Driver's License** • **All Medical & Accident Reports**

Who referred you to our Center ?

Print Full Name of patient, doctor, attorney, website, directory or event

☐Referred by* ☐Internet website* ☐Health Fair/Event* ☐Yellow Pages* ☐Met Doctor* ☐Drove by

*Name:_____

Patient Information

Patient's First & Last Name: _____

Date of Birth: _____ Gender: Male Female Marital Status: single married widowed divorced

Address: _____ Apt/Suite#:_____ City: _____ State: ___ Zip:_____

Home Phone #: ( )_____ Cell/Pager/Other #: ( )_____

Email address:_____

Social Security #:_____ Driver's License #: _____

Emergency Contact Name: _____ Tel #: ( ) _____

Relationship to Patient:_____

Address: _____ Apt/Suite#:_____ City: _____ State: _____ Zip:_____

Home Phone #: ( ) _____ Cell/Pager/Other #: ( )_____

Work Phone #: ( ) _____ Extension: _____ Email:_____

Patient Employment Information (CURRENT JOB)

☐ Not employed ☐ Student ☐ Self-employed→Business Name: _____

Employer/School: _____Occupation: _____

Address: _____ Apt/Suite#:____ City: _____ State: ____ Zip:_____

Work Phone #: ( ) _____ Extension: _____

Patient Health Insurance Information (CURRENT INSURANCE)

Do you currently have Health Insurance: ☐ No ☐ Yes→ Complete below

Name of Insured/Subscriber: _____

Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Legal Guardian ☐ Other: _____

Insurance Company: _____

Plan Type: ☐ PPO ☐ HMO ☐ Medicare ☐ Other: _____

ID #: _____ Policy #: _____ Group #: _____

Insurance Tel # (on back of card): ( ) _____

Name of Primary Care Doctor: _____ Tel #: ( ) _____

Patient's Attorney Information

Have you hired an attorney: ☐No ☐Yes→ Attorney First & Last Name:_____

Law Firm/Office Name:_____

Paralegal/Assistant's Name: _____

Address: _____ Suite#:_____ City: _____ State: ____ Zip: _____

Home Phone #: ( ) _____ Cell/Pager/Other #: ( )_____

Work Phone #: ( ) _____ Extension: _____

Fax: ( ) _____ Email address:_____

Employer's Insurance Information for Workers Compensation

Name of Work. Comp. Insurance Company:_____
Address: _____ Suite#: _____ State: _____ Zip:_____
Claim#: _____ WCAB (Appeals Board Case) #: _____
Claims Adjuster Name (whom you spoke with): _____
Address to mail claim: _____ City:_____ State:_____
Tel.#: ( ) _____ extension: _____ Fax.#: ( ) _____
Name of M.D. who referred you: Dr. _____
Doctor's Office Tel#: ( ) _____ **Address:**_____
Prescribed treatment plan (# visits per week): N Y →_____

A. Accident & Injury Information

1) EMPLOYMENT INFORMATION (AT TIME OF ACCIDENT)
Job Title (at time of injury): _____
Employer/Company name (at time of injury): _____
Nature of business (e.g.: school, police, manufacturing, construction, etc...): _____
_____
Supervisor Name: _____
Supervisor Phone#: ( ) _____ Extension: _____
Employer Address: _____
City: _____ State: _____ Zip: _____

2) ACCIDENT / INJURY DETAILS: Date: _____ Time: _____ AM/PM
Address:_____
Location/Place of Injury:_____
City: _____ State: _____ Zip: _____

Work Conditions/Environment:_____
Date injury reported to supervisor: _____
Date last worked [job at time of injury]: _____

►**Have you received any AWARD for FUTURE MEDICAL CARE: N Y →** _____
►**Do you have a copy of this award letter: N Y →** _____
►**Are you now "PERMANENT & STATIONARY" ("P & S"): N Y →** _____

Describe the accident in your own words using specific details:
_____
_____
_____
_____

Did you fill out an injury form at work or an **"Employee Claim for Work Comp Benefits"? N Y**
Did authorities/personnel arrive on scene: **N Y→**Was a written report created? **N Y**
Do you have a copy of any reports: **N Y →** _____

Did you speak to anybody or did anybody approach you: **N Y→** _____
Were photos taken of incident scene: **N Y →** Who took photos:_____
Were there any witnesses to the accident: **N Y →** Witness Names & Tel. numbers:
_____

Were you in a vehicle that belonged to your company of employment (e.g. company car) at the time of injury? N Y → _____
Is there a Personal Injury claim also being filed? N Y → _____

B. Your Current Injuries & Symptoms due to Incident

1) **Please describe how you felt...[e.g. cuts, scrapes, bruises, pain, stiff, sore, emotions, etc..]**
IMMEDIATELY AFTER the incident: ☐unconscious ☐ dizzy/dazed ☐disoriented ☐nervous ☐nauseous ☐upset ☐weak ☐other:_____

LATER that day: _____

The NEXT day: _____

2) CURRENT COMPLAINTS: Check **ALL** symptoms you have noticed since the incident:
***Note Your Current Intensity of Pain (0=no pain through 10=constant severe pain).**
***CIRCLE R=right OR L=left OR BOTH**

☐*Head pain=__/10	☐jaw/TMJ pain	☐impatient	☐face flushed	☐feet cold
☐*Neck pain=__/10	☐chest pain	☐shortness of breath	☐buzzing in ears	☐hands cold
☐*Upper back pain=__/10	☐eye pain	☐coughing	☐hiccups	☐fever
☐*Mid back pain=__/10	☐abdominal pain	☐tension	☐grinding teeth	☐vomiting
☐*Low back pain=__/10	☐jaw clenching	☐irritability	☐nervous	☐restless
☐*R/L Shoulder pain=__/10	☐dizziness	☐fatigue	☐loss of balance	☐stomach upsets
☐ *R/L Elbow pain=__/10	☐head is "heavy"	☐depression	☐fainting	☐constipation
☐ *R/L Wrist pain=__/10	☐mood swings	☐light sensitivity	☐loss of smell	☐cold sweats
☐ *R/L Hip pain=__/10	☐disoriented	☐loss of memory	☐loss of taste	☐hot sweats
☐ *R/L Knee pain=__/10	☐unconscious	☐ringing in ears	☐diarrhea	☐anxiety
☐ *R/L Ankle pain=__/10	☐headaches	☐blurred vision	☐confused	☐difficulty sleeping
☐ *R/L Foot pain=__/10	☐difficulty swallowing		☐fear of driving/entering a vehicle	
	☐ loss of concentration/difficult to focus on tasks			☐ nightmares

☐ **Broken bones**→regions:_____
☐ **Open cuts/Scrapes**→regions:_____
☐ **Bruising (blue/red discoloration)**→regions:_____
☐ **Muscle spasms**→regions:_____
☐ **Muscle Weakness**: →regions: _____
☐ **Numbness/Tingling/Pins & Needles**:→regions:_____
☐ **Head pain** that travels/radiates to: ☐ left side of head ☐ right side of head ☐ both sides of head ☐ front of head ☐ back of head ☐ top of head ☐ neck ☐ other:_____
☐ **Neck pain** that travels/radiates to: ☐ left shoulder ☐ left arm ☐ left forearm ☐ left hand ☐ right shoulder ☐ right arm ☐ right forearm ☐ right hand ☐ other:_____
☐ **Low Back pain** that travels/radiates to: ☐ left buttock ☐ left thigh ☐ left knee ☐ left foot ☐ right buttock ☐ right thigh ☐ right knee ☐ right foot ☐ other:_____
☐ **ANY OTHER SYMPTOMS**:_____

3) **List any part of your body that struck any object/surface** (eg: floor, table, chair, door, window, etc.):
_____

4) **Were you knocked unconscious:** ☐No ☐Yes→For how long: ____ minutes/hours/days ☐ not sure
5) **Since this injury occurred, are your symptoms:** ☐ getting worse ☐ no change ☐ improving

6) Where did you go RIGHT AFTER the accident? CHECK ALL THAT APPLY:

→☐ **HOSPITAL / URGENT CARE** OR →☐ **DOCTOR'S OFFICE**

How did you get to the hospital/office: ☐ Ambulance ☐ Drove yourself ☐ Someone else drove you

Were you offered transportation via ambulance: ☐No ☐Yes → Reason why you declined ambulance:

☐ too scared ☐ could not afford it ☐ no health insurance ☐ just wanted to go home

☐ Other:_____

Hospital/Clinic Name:_____ **Doctor's name:**_____

X-rays/MRI/CT scans taken: ☐ Head ☐ Neck ☐ Back ☐ None ☐ Other:_____

All Diagnoses:_____

Treatment/Supports received: ☐ exam only ☐ stitches ☐ bandages ☐ neck collar ☐ crutches ☐ cane

☐ Other:_____

All medications prescribed: ☐ "Pain killer" ☐ "Muscle relaxer" ☐ "Anti-Inflammatory" ☐ None

☐ Other Medications: _____

Instructed to: ☐ Follow-up with primary doctor ☐ Get physical therapy ☐ Take prescribed medications

☐ Read "Care for concussions" ☐ Read "Care for sprains-strains" ☐ Read "Care for work injury"

☐ Other:_____

→☐ **HOME - If you went home, did you treat yourself:** ☐No ☐Yes→ ☐ice pack ☐hot shower ☐rest

☐"Over the counter" medications: ☐Tylenol ☐Motrin ☐Aleve ☐Aspirin ☐Excedrin

☐ Other:_____

How did you get home: ☐ Drove yourself ☐ Someone else drove you

→☐ **OTHER LOCATION**→ Details:_____

7) As a result of this incident, have you seen any OTHER Doctor, Health Care Provider or Therapist:

☐ **URGENT CARE / AFTER HOURS CLINIC → Date(s):** _____

☐ **DOCTOR / PROVIDER OFFICE → Date(s):** _____

Clinic name:_____ **Doctor/Provider name:**_____

Area of Specialty/Type of Provider: ☐ Medical Doctor ☐ Primary Care Dr ☐ Orthopedic surgeon ☐ Pain Management Dr ☐ Chiropractor ☐ Acupuncturist ☐ Physical therapist ☐ Massage therapist ☐ Other: _____

All Diagnoses:_____

X-rays/MRI/CT scans taken: ☐ None ☐ Head ☐ Neck ☐ Back ☐ Other:_____

Treatment received: ☐ Exam only ☐ Surgery ☐ Stitches ☐ Bandages ☐ Injections

☐ Other:_____

All medications prescribed: ☐ "pain killer" ☐ "muscle relaxer" ☐ "anti-inflammatory" ☐ none

☐ Other Medications: _____

Instructed to: ☐ Follow-up with primary doctor ☐ Get physical therapy ☐ Take prescribed medications

☐ Rest ☐ No instructions given ☐ Other:_____

8) Any other treatment received for this condition: ☐ No ☐Yes→Date(s) of treatment_____

Treatment Details:

_____

9) IF YOU DID NOT SEE A DOCTOR WITHIN THE FIRST FEW WEEKS, DESCRIBE WHY:

☐ no transportation ☐ no appointment available ☐ could not afford care ☐ no pain was noticed

☐ work/home schedule conflicts ☐ required to work to pay rent/bills ☐ no health insurance

☐ I thought pain/symptoms would "go away"

☐ Other:_____

C. Your Daily Activities at Home/Work/School

1) Since this injury, have you lost time from work/school: ☐ No ☐Yes→List dates missed:

_____

Last day worked: ☐ Date of Incident ☐ Other date:_____
Current salary: $_____ per hour/week/month/year Tips (Avge per day): $_____
Total amount of lost pay to date: $ _____
Are you being compensated for time lost from work: ☐ No ☐Yes→
If YES, type of compensation you are receiving:_____

2) **Are you currently working?**
☐**No →** Are you: ☐ looking for employment ☐ "stay at home" parent ☐ other:_____
☐**Yes →** Are you on: ☐ regular duty ☐ light duty ☐ part time ☐ other:_____
Are you currently a student? ☐**Yes →** Are you taking classes: ☐ full time ☐ part time
☐ other:_____

3) **Do you notice any activities that are difficult to do at WORK / SCHOOL as a result of this injury?**
☐No ☐Yes → Details:_____

4) **Do you notice any activities that are difficult to do at HOME as a result of this injury?**
☐No ☐Yes → Details:_____

5) **Since the incident, do you have more difficulty at home with raising children?** ☐N/A ☐No ☐Yes→
Kids_____ → List Ages:_____

6) **Do you require assistance from another family member/friend or hired help/nanny?**
☐No ☐Yes→Details:_____

7) **Since the incident, are there any activities that you are now no longer able to enjoy OR have difficulty doing due to incident** (e.g. hobbies, sports, domestic duties, household duties, etc....)?
☐No ☐Yes→Details:_____

D. Current Health Status

1) What makes your condition worse: ☐sitting ☐standing ☐walking ☐bending forward
☐lying down on back ☐ Other:_____

2) What makes your condition better: ☐ ice pack ☐ hot shower ☐ rest ☐ standing ☐lying on back
☐ Medications→_____
☐ Other:_____

3) Describe the quality of your pain/condition: ☐ sharp ☐ dull ☐ achy ☐ burning ☐ throbbing
☐ Other quality:

4) What percent of the time do you have your pain / condition (% of day):
☐ constant [100%] ☐ frequent [75%] ☐ intermittent [50%] ☐ occasional [25%]

E. Previous Medical History [NOT relating to current injury/incident]

1) Current Age: _____ Height: feet=____ inches=____ Weight: _____pounds
2) Date of Last Medical Exam/Physical: _____ ☐don't recall
Doctor/Office Name:_____
3) Results/Findings/Diagnoses:_____
4) Results of Blood/Lab Tests: _____
5) Results of X-rays/CT/MRI: _____
6) Other Tests: :_____
7) **For Women**: Is there any chance you may be pregnant: ☐ No ☐ Yes→# weeks:

8) **All Prescribed Medications:**_____

9) **All Over-The-Counter Medications:** _____

10) **Do you have any congenital (from birth) factors which relate to your condition:**
☐ No ☐ Yes→details/dates: _____

11) **Do you have any previous illnesses/complications from previous injuries:**
☐ No ☐ Yes→details/dates: _____

12) **Have you ever been involved in any accident <u>in the last 10 years</u>:** ☐ No ☐ Yes→details/dates:

_____

Treatment Received for <u>previous</u> injuries: ☐ None ☐ Yes→details:_____

_____

Any residual pain/symptoms/complications from <u>previous</u> injuries: ☐ None ☐ Yes→details:

_____

13) **Did you have any physical complaints <u>before</u> this incident:** ☐ No ☐ Yes→_____

_____

14) **Have you <u>ever</u> been to the hospital for any reason (surgery, trauma, childhood, etc.):**
☐ No ☐ Yes→details/dates:_____

<u>EXCLUDING injuries from this accident, have you EVER had injuries to any of the following regions? Please state RIGHT/LEFT side, details, dates, any complications, healed/resolved:</u>

YES	*NO*		*YES*	*NO*	
☐	☐	Head _____	☐	☐	Hip [R or L] _____
☐	☐	Neck _____	☐	☐	Knee [R or L] _____
☐	☐	Spine _____	☐	☐	Thigh [R or L] _____
☐	☐	Shoulder [R or L] _____	☐	☐	Calf [R or L] _____
☐	☐	Elbow [R or L] _____	☐	☐	Ankle [R or L] _____
☐	☐	Wrist [R or L] _____	☐	☐	Foot [R or L] _____
☐	☐	Hand [R or L] _____	☐	☐	Toes [R or L] _____
☐	☐	Fingers [R or L] _____	☐	☐	OTHER _____

F. Previous Medical Concerns [NOT relating to current injury/incident]
Check ALL of the following that apply to you.

YES	*NO*		*YES*	*NO*	
☐	☐	Loss of consciousness/head injuries	☐	☐	Lupus
☐	☐	Seizures/Epilepsy/Convulsions	☐	☐	Diabetes
☐	☐	Dizziness/Fainting	☐	☐	Pacemaker
☐	☐	Visual disturbances/Eye problems	☐	☐	Hernia
☐	☐	Nose, throat, breathing problems	☐	☐	Osteoporosis
☐	☐	Asthma, allergies, allergic reactions	☐	☐	Sleep apnea/sleep conditions
☐	☐	Diarrhea, constipation	☐	☐	Menstrual problems
☐	☐	Numbness in groin/buttocks	☐	☐	Urinary problems
☐	☐	Abnormal/rapid weight gain/loss	☐	☐	Recent fever
☐	☐	High blood pressure	☐	☐	Corticosteroid – cortisone, prednisone
☐	☐	Artificial joints	☐	☐	Birth control pills
☐	☐	Pain at night	☐	☐	Alcohol/tobacco/drug abuse
☐	☐	Pain unrelieved by position/rest	☐	☐	Rheumatoid arthritis
☐	☐	Morning pain/stiffness	☐	☐	Blood disease: _____
☐	☐	Cancer/tumor/lumps: _____			
☐	☐	Stroke [date/complications]:_____			

<u>Any Organ Problems/Diseases</u>: ☐Heart ☐Liver ☐Kidney ☐Stomach ☐Pancreas ☐Gall bladder ☐Lungs ☐Intestines ☐Prostate ☐Uterus ☐Ovaries ☐Thyroid ☐Other:_____