



Workers' Compensation Questionnaire

Was your accident directly related to your work? YES NO

Briefly describe the events that occurred just before and during your accident: _____

Did you report your accident to your employer? YES NO

Employer at the time of injury: _____

Did accident render you unconscious? YES NO

If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Describe any treatment you received: _____

Were x-rays taken? YES NO

Was medication prescribed? YES NO

If yes, what type: _____

Are your work activities restricted as a result of this injury? YES NO

Indicate the symptoms that are a result of this accident:

Dizziness

Difficulty Sleeping

Arms /Shoulder Pain

Upper/Mid Back Pain

Memory Loss

Irritability

Numb Hands/Fingers

Lower Back Pain

Headache

Fatigue

Chest Pain

Back Stiffness

Blurred Vision

Tension

Shortness of Breath

Numb Feet/Toes

Ears Ringing/Buzzing

Neck Pain

Stomach Upset/Nausea

Stiff Neck

Jaw Problems

Leg Pain

Other: _____



Is your condition getting worse? YES NO

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on Stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking Short Distance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Operating Equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Typing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Signature: _____ Date: _____

Please note this form is to be used in conjunction with any forms required by your state's workers' compensation board. This form is not intended to be a substitute for any state or other authority's forms.