

Work Related Accident/Injury Questionnaire

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Date of Accident/Injury: _____ Time of Accident: _____

Employer Information: Employer: _____ Your Occupation: _____

Have you had a **previous Workers Comp injury**? __ Yes __ No If yes, when: _____

Have you **reported this accident** to your employer? __ Yes __ No Accident claim filed? _____ Yes __ No

Name of **person** accident **reported to**? _____ **Witness** to accident? _____

Injured at? _____ City _____ State _____ Zip _____

Length of time employed prior to accident? _____

Description of Accident: Please **describe how** you injured yourself: _____

If **lifting**, how much **weight** was involved? _____ What **position** were you in? _____

Was the accident **caused by someone else**? _ Yes _ No If yes, who? _ What, if any, kind of **equipment** was involved? _____

What is the **function of this equipment**? _____

Was the accident a result of **failure of equipment or a product**? _ Yes __ No If yes, what was it? _____

If **struck by an object**, what was it? _____ **Where** were you struck? _____

If you fell, how far did you fall? _____ Inside _ Outside

What body parts were impacted? __ Chest __ Knee __ Shoulder __ Hand __ Foot __ Hip __ Back _____ Other

What physical conditions may have contributed to the present injury? (ie...icy, slippery floor, object in the way, etc.)

Job Description/Work Activities: In a **typical 8 hour** workday, **how many hours** do you spend: _____ Sitting

_____ Standing _____ Walking

On the job, I perform the following activities:

	<u>Not at All</u>	<u>Occasionally</u>	<u>Frequently</u>	<u>Continuously</u>
Bend/Stoop				
Squat				
Crawl				
Climb				
Reach above shoulder level				
Crouch				
Kneel				
Balancing				
Pushing/Pulling				

Current Disability/Work Status: Last Date Worked: _____

Are you **off work now**? ___ Yes ___ No If yes, authorized **by who**? _____

Have you **lost time from work** as a result of this accident? ___ Yes ___ No If yes, **are you being compensated** for time lost from work? ___ Yes ___ No Has **modified work or a reduced work load** been offered to you as a result of your injuries? ___ Yes ___ No

Past Medical Treatment: Have you been treated by **another doctor** for this injury? ___ Yes ___ No If yes, please list the doctors name and location: _____

What **type of treatment** did you receive? _____

How long were you treated by this doctor? _____

Were X-rays taken? ___ Yes ___ No **Date of x-rays**? _____ **Where** were they taken? _____

Since your accident, are you: ___ Improved ___ Unchanged ___ Getting Worse

What type of **medications** are you currently taking? _____

Do these medications help? ___ Yes ___ No

Have you had **Physical Therapy/chiropractic care**? ___ Yes ___ No If yes, how often? ___ Daily ___ Every other day ___ Several times a week ___ Weekly ___ Every other week ___ Monthly ___ Other

Does Physical Therapy help? ___ Yes ___ No ___ I don't know

Prior to this accident, have you **ever had any physical complaints similar** to what you have now? ___ Yes ___ No

If yes, please explain: _____

Were these similar complaints **the result of a previous accident**? ___ Yes ___ No Please provide **details of that accident**: _____

Current Symptoms/Complaints: Check the symptoms you have noticed since the accident/injury:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Faced Flushed | <input type="checkbox"/> Feet cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head seems Heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Ears Ringing | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Jaw 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: _____

By my signature below I am verifying that the above information is true to the best of my knowledge.

Signature

Date