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? (form 801)___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:________________________________

____

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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:

	Not at All	Occasionally	Frequently	Continuously
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

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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:

▫ Headache	▫ Irritability	▫ Numbness in Toes	▫ Faced Flushed	▫ Feet cold
▫ Neck Pain	▫ Chest Pain	▫ Shortness of Breath	▫ Buzzing in Ears	▫ Hands cold
▫ Neck Stiff	▫ Dizziness	▫ Fatigue	▫ Loss of Balance	▫ Stomach Upset
▫ Sleeping Problems	▫ Head seems Heavy	▫ Depression	▫ Fainting	▫ Constipation
▫ Back Pain	▫ Pins & Needles in Arms	▫ Lights bother eyes	▫ Loss of Smell	▫ Cold Sweats
▫ Nervousness	▫ Pins & Needles in Legs	▫ Loss of Memory	▫ Loss of Taste	▫ Fever
▫ Tension	▫ Numbness in Fingers	▫ Ears Ringing	▫ Diarrhea	▫ 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:______________

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

________________________________ ________________________________

Signature Date