Premier Healthcare of Placerville

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WORKERS' COMPENSATION INJURY QUESTIONNAIRE

Name: ______________________________ Today's Date: ______________

Social Security#: ______________________ Date of Birth: ______________

To insure greater accuracy in the assessment of your condition, we ask that you answer the following questions as completely as possible. Please sign the bottom of each page in the space provided.

1. What is your chief complaint (s)? ______________________________

____

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2. Have you ever seen any of our doctors before? ( ) Yes ( ) No If so, When? ______________

____

3. What was the date and time of your accident? Date: ______________ Time: ______________

4. Who was your employer at the time of the accident? ______________________

5. How long had you worked with the above employer prior to this injury? ______________

6. Name all employers you have worked for the past five years. 1. ______________

   2. ______________ 3. ______________

7. What type of work were you doing when this injury occurred? ______________

____

8. Where did the accident happen? ______________________________

9. How did the accident happen? ______________________________

____

10. Was the accident reported to someone? ( ) Yes ( ) No – If so, Who? ______________

11. Have you had any other serious accidents which required medical care? ( ) Yes ( ) No – If so, When? ______________

____

12. Have you ever been awarded any type of disability? ( ) Yes ( ) No – If so, For What? ______________

   By Who? ______________________________

SIGNATURE ______________________ Date ______________

13. What medical care have you received as a result of this injury, from whom and for how long?

____

____

14. I am ( ) improved ( ) unchanged ( ) getting worse. ______________________________

15. What medicines are you talking, if any? ______________________________________

____

16. Does the medicine help? If yes – How? ____

If no – Why? ____

17. Have you had Physical Therapy? ( ) Yes ( ) No – If yes, How often? ____________________

18. Did the Physical Therapy help? ( ) Yes ( ) No

19. Have you ever had any physical complain similar to those that you are now complaining of before this accident?

Please discrbe: ____

____

20. Have you had any serious illnesses that required hospitalization? ( ) Yes ( ) No – If yes, Describe ________

____

21. Have you had any surgeries, and when? ( ) Yes ( ) No – If yes, Describe ____________________

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22. Hve you had any fractures, and when? ( ) Yes ( ) No – If yes, Describe ____________________

____

23. Have you had any nervous our mental illnesses? Any phychiatric care? If yes, Describe ______________

____

24. Have you received a medical discharge from the Armed Forces? ( ) Yes ( ) No

25. Have you returned to work since this accident? ( ) Yes ( ) No

If you have retured to work since your work accident, please fill out the chart below including dates you have worked,for whom and occupation.

DATE	EMPLOYER	OCCUPATION	LIGHT/REG.DUTY	FULL/PART TIME

SIGNATURE ______________________________ Date ____________________

BACK PAIN

I have pain in my:	( ) low back	( ) mid back	( ) upper back
My pain began:	( ) gradually	( ) suddenly	
I have pain:	( ) sometimes	( ) all of the time	
My pain goes into my:	( ) right leg	( ) left leg	( ) both
I have tingling and/or numbness in my:	( ) right leg	( ) left leg	( ) both

My pain is works when I:	cough or sneeze	( ) Yes	( ) No
	sit	( ) Yes	( ) No
	bend	( ) Yes	( ) No
	walk	( ) Yes	( ) No
	lift	( ) Yes	( ) No
	push	( ) Yes	( ) No
	pull	( ) Yes	( ) No
My back is worse with sexual activity:		( ) Yes	( ) No
My pain wakes me up in the middle of the night		( ) Yes	( ) No
Changes in the weather affect my pain:		( ) Yes	( ) No

NECK PAIN

My pain began:	( ) gradually	( ) suddenly		
I have pain:	( ) sometimes	( ) all of the time		
My pain goes into my:	( ) right arm	( ) left arm	( ) both	
I have tingling and/or numbness in my:		( ) right arm	( ) left arm	( ) both

My pain is works when I:	cough or sneeze	( ) Yes	( ) No
	bend forward	( ) Yes	( ) No
	lift	( ) Yes	( ) No
	push	( ) Yes	( ) No
	pull	( ) Yes	( ) No
	turn my head	( ) Yes	( ) No

I have tingling and/or numbness in my: ( ) right arm ( ) left arm ( ) both

My pain wakes me up in the middle of the night ( ) Yes ( ) No

SIGNATURE ______________________________ Date ______________________

Changes in the weather affect my pain: ( ) Yes ( ) No

Neck Pain – Continued:

I have neck stiffness: ( ) Yes ( ) No
I have headaches: ( ) Yes ( ) No

If I do get headaches, they occure: ( ) Sometimes ( ) All of the time

Please use the space provided below to descibe any current medical complaints you are experiencing which were not previously covered on the questionnaire or for any additional comments you wish to make regarding your condition.

SIGNATURE ______________________________ Date ______________________

Employee Description of Job Requirements

Employee Name: ____

1 Check the frequency of activity required of the employee to perform the job:

ACTIVITY (Hours per day)	Never (0 hours)	Occasionally (up to 3 hours)	Frequently (3-6 hours)	Constantly (6-8 hours)
a. Sitting				
b. Walking				
c. Standing				
d. Bending (neck)				
e. Bending (waist)				
f. Squatting				
g. Climbing				
h. Kneeling				
i. Crawling				
j. Twisting (neck)				
k. Twisting (waste)				
Hand Use: Dominant hand R L				
1. Repetitive use of had required				
2. Simple grasping (right hand)				
3. Simple grasping (left hand)				
4. Power grasping (right hand)				
5. Power grasping (left hand)				
6. Fine maniupulation (right hand)				
7. Fine maniupulation (left hand)				
8. Pushing and pulling (right hand)				
9. Pushing and pulling (left hand)				
10. Reaching (above shoulder level)				
11. Reaching (below shoulder level)				
12.Typing/Computer				

2. Please indicate the daily lifting and carrying requirements of the job:
Indicate the height the object is lifted from floor, table or overhead location and the distance the obect is carried.

	LIFTING					CARRYING				
	Never 0 hours	Occassionaly 0 – 3 hours	Frequently 3-6 hours	Constantly 6-8 + hours	Height	Never 0 hours	Occassionaly 0 – 3 hours	Frequently 3-6 hours	Constantly 6-8 + hours	Distance
0-10 lbs.										
11-25 lbs.										
20-50 lbs.										
51-75 lbs.										
76-100 lbs.										
100 + lbs.										

Describe the heaviest item required to cary and the distance to be carried.

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SIGNATURE ______________________ Date ______________________