Work-Related Injury Questionnaire

Patient Name: _____ Date: _____

Employer at time of injury: _____ Phone: _____

Employer's Address: _____ City: _____ State: ____ Zip: _____

Job Title: _____ Length of Time Working Prior to Accident: _____

Type of Work Being Performed at Time of Injury: _____

Describe Injury / Accident: _____

_____

Before Accident, have you experienced similar / same symptoms? YES NO If yes, describe: _____

_____

List and Describe Any Additional Injuries / Accidents: _____

Insurance Company_____ Adjuster Name & Phone Number_____
Claim Number_____

If you have returned to work since your accident, please complete the following information:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY REGULAR DUTY	FULL-TIME PART-TIME

Job Description:

"On the Job I Lift / Carry"	NONE	INFREQUENT 1 X P / HR	OCCASIONAL UP TO 15X P / HR	INTERMITTENT UP TO 60X P / HR	CONSTANT 60 + P / HR
Up to 10 LBS	☐	☐	☐	☐	☐
11-25 LBS	☐	☐	☐	☐	☐
26-50 LBS	☐	☐	☐	☐	☐
51-75 LBS	☐	☐	☐	☐	☐
76-100 LBS	☐	☐	☐	☐	☐
100 + LBS	☐	☐	☐	☐	☐
BENDING	☐	☐	☐	☐	☐
CRAWLING	☐	☐	☐	☐	☐
CROUCHING	☐	☐	☐	☐	☐
CLIMBING	☐	☐	☐	☐	☐
KNEELING	☐	☐	☐	☐	☐
PUSHING	☐	☐	☐	☐	☐
PULLING	☐	☐	☐	☐	☐
REACHING					
ABOVE SHOULDER LEVEL	☐	☐	☐	☐	☐
AT SHOULDER LEVEL	☐	☐	☐	☐	☐
BELOW SHOULDER LEVEL	☐	☐	☐	☐	☐

In a typical 8-hour workday, how many hours do you sit _____ stand _____ walk _____ ?
On the job, do you perform repetitive lifting? YES NO bending? YES NO
Do your hands perform repetitive actions, such as: ☐ simple grasping ☐ firm grasping ☐ fine manipulating ?
Are your feet used for repetitive movements, such as operating foot controls? YES NO

Date & Time of Accident: _____ ☐ a.m. ☐ p.m.
Was your accident directly related to your work? YES NO
Briefly describe the events that occurred just before and during your accident: _____

_____

Give the address where the accident occurred (if other than employer's address): _____

_____

Was anyone else present during your accident? YES NO
Did you report your accident to your employer? YES NO
What recommendations did your employer make just after the accident? _____

_____

Insurance Company_____ Adjuster Name & Phone Number_____
Claim Number_____
Has this type of accident happened to you before? YES NO
In general:

Is your job physically stressful? YES NO
Is your job mentally stressful? YES NO
Is your workplace noisy? YES NO
Have you changed jobs in the last year? YES NO

After Injury

Did the accident render you unconscious? YES NO If yes, for how long? _____
Please describe how you felt immediately after the accident: _____

_____

Have you gone to a hospital or seen any other doctor regarding this accident? YES NO

If yes, when did you go? ☐ Just after the accident ☐ the next day ☐ 2 days plus
How did you get there? ☐ Ambulance ☐ Private Transportation
Name of hospital and/or attending doctor: _____ ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S.
Describe any treatment you received: _____
Were X-rays taken? YES NO
Was medication prescribed? YES NO If yes, what was prescribed? _____

Have you been able to work since this injury? YES NO
Are your work activities restricted as a result of this injury? YES NO

Have you retained an attorney? YES NO

If yes, whom? _____ His/Her Phone #: _____

Recovery

How many hours are in your normal workday? _____
Please indicate your daily job duties and any job-related activities which you are occasionally asked to perform:

☐ Standing	☐ Driving	☐ Operating Equipment
☐ Sitting	☐ Twisting	☐ Work with Arms Above Head
☐ Walking	☐ Crawling	☐ Typing
☐ Lifting	☐ Bending	☐ Stooping

☐ Other: _____

What positions can you work in with minimum physical effort and for how long? (or ☐ N/A)

_____

_____

Prior to the injury, were you capable of working on an equal basis with others your age? YES NO
Do you work with others who can help you with any heavy lifting? YES NO
While in recovery, is there any light duty work you could request? YES NO

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____