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Worker's Compensation Injury History Questionnaire

Patient Name _____ Patient DOB _____/_____/_____

Date of Injury _____/_____/_____ Time _____ ○AM ○PM
Place of Injury_____
What is your job description? _____
Accident reported to employer? No Yes
Name of person you reported accident to _____
Give full description of how accident happened:
_____
_____
_____
_____
_____

Have you lost time from work because of this accident? ○No ○Yes
If yes, how much time? _____
Other doctors seen for this condition (Doctor's Name)_____
Diagnosis _____
What treatment given? (Circle all that apply) ○None ○X-rays ○Pain Medication ○Cervical Collar ○Bandaged ○Stitches ○Muscle Relaxants ○Physical Therapy ○Instructed Regarding Concussion ○Instructed Regarding Sprains & Strains ○Instructed to Call an Orthopedist ○Instructed to Call a Private Physician ○Referred to This Office
○Other _____

Any previous Workers Compensation injuries ○No ○Yes
If yes, date(s) of previous injuries _____
Describe previous Workers Compensation injuries_____
_____

Current symptom(s) worse at anytime? (Check all that apply)
○Morning ○Afternoon ○Evening ○Night ○Unaffected by time

Have you ever received Chiropractic Care? ○No ○Yes
Name of Chiropractic Physician _____
Approximate date of last visit _____
What were you being treated for?_____

DUTIES UNDER DURESS SUMMARY
Check the day-to-day living duties that are difficult or painful for you to do as a result of your injuries from this work injury.
Work:
Check all activities that you have difficulty with:
○Lifting ○Bending ○Sitting ○Walking ○Computer Duties ○Other _____
How long can you sit before pain/discomfort disrupts you?_____
How long can you stand before pain/discomfort disrupts you?_____

Patient Name _____DOB ___/_____/_____Date _____

DUTIES UNDER DURESS SUMMARY (cont'd)

Personal Care:

Check all activity that you have difficulty with doing:
○Getting dressed ○Brushing hair ○Showering ○Using the bathroom ○Putting on shoes/socks

Domestic Duties:

Check all activities that you have difficulty with doing:
○Vacuuming ○ Doing Laundry ○Sweeping Floor ○Taking Care of Kids ○Cleaning
○Preparing Meals ○Other _____

Household Duties:

Check all activities that you have difficulty with doing :
○Lifting household objects ○Yardwork/Gardening ○Transportation ○Shopping ○Taking Out Trash ○Other _____

School/Studies:

Check all activities that you have difficulty with doing:
○Studying ○Lifting ○Bending ○Sitting ○Walking ○Computer Duties ○Other_____

Sports Activities that you are having difficulty with as a result of your current symptom(s):
○Social _____○Competitive _____