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