Worker's Compensation Questionnaire

Patient's Name ______________________________ File # ___________________ Date:

Employer's Name: ____
Address: ____
City: _________________________________ State: _____________ Zip: _______________
Phone Number: (____) ____ - _______

Date of Accident: ___/___/_____ Claim Number: ____
Date Reported to Employer: ___/___/_____ Reported to Whom: __________________________________
Occupation: ____

Please Describe How the Injury Occurred: ____
____
____
____

What Were Your Symptoms Following the Accident: ____
____
____
____

When Did the Symptoms Begin? ☐ Immediately ☐ Hours _____ Days Other ________________
Did Your Employer Send You To A Doctor? Y N Were You Hospitalized? Y N

Have You Been Treated By Any Other Doctor For This Accident? Y N
If Yes, Name of Doctor(s) and Phone Number(s): ____
What Medications Are You Currently Taking: ____
____
____

Are You Currently Working? Y N

Does Your Present Position Involve: ☐ Lifting ☐ Sitting for Long Periods ☐ Repetitive Motion

Is the Pain Worse In: ☐ Morning ☐ Afternoon ☐ Night

Are Your Activities Restricted Due to the Accident? Y N

Since the Accident Are Your Symptoms Improving? Y N

Is There Anything That You Could Do Before the Accident That You Can Not Do Now? Y N

☐ Work	☐ Exercising	☐ Brushing Teeth	☐ Reaching Over Head
☐ Sleep	☐ Lifting	☐ Standing	☐ Playing w/ Kids
☐ Sit	☐ Shopping	☐ Using Bathroom	☐ Cooking
☐ Walk	☐ Drive	☐ Bending Over	☐ Cleaning House