Worker's Compensation History Form

Patient's Name: _____ Date: _____ / _____ / _____

Address: _____ City: _____ State: _____ Zip: _____

Birthday: _____ / _____ / _____ Age: _____ Sex: _____ SSN#: _____

Name of compensation carrier: _____ Phone #: _____

Address of carrier: _____ City: _____ State: _____ Zip: _____

Employer's name: _____ Phone #: _____

Employer's address: _____ City: _____ State: _____ Zip: _____

- Type of business: _____ Your occupation: _____
- Date injured : _____ / _____ / _____ Hour: _____ ❑ AM ❑ PM
- Last date worked: _____/ _____ / _____ Are you off work? ❑ Yes ❑ No
- Previous worker's compensation injury? ❑ Yes ❑ No
- Accident reported to employer? ❑ Yes ❑ No
  - Name of person to whom the accident was reported: _____
- Injured at: _____
  - City: _____ State: _____ Zip: _____
- Length of time worked there prior to accident:
  _____
- Type of work being done at the time of injury:
  _____
- In your own words, please describe the accident:
  _____
  _____
  _____
- Have you been treated by another doctor for this accident? ❑ Yes ❑ No
  - If yes, please list doctor(s)' names and addresses:
    _____
    _____
    _____
  - What type of treatment did you receive?
    _____
    _____
  - How long were you treated by this doctor(s)?
    _____
    _____

- Are you: ❑ Improved ❑ Unchanged ❑ Getting worse

- What types of medications are you taking?

  _____
  _____
  _____
  _____
  _____

- Have you had physical therapy? ❑ Yes ❑ No
  - If yes, how often?
    - ❑ Daily ❑ Weekly ❑ Other: _____
    - ❑ Every other day ❑ Every other week
    - ❑ Several times a week ❑ Monthly
  - Did the physical therapy help?
    - ❑ Yes ❑ No ❑ I do not know

- Prior to this accident, have you ever had any of the physical complaints similar to what you have now?
  - ❑ Yes ❑ No ❑ I do not know

  If yes, describe:

  _____
  _____
  _____

  Were these similar complaints the result of a previous accident(s)?
  - ❑ Yes ❑ No

  If yes, please provide details of the accident(s):

  _____
  _____
  _____

- Have you had any other serious accidents which required medical care?
  - ❑ Yes ❑ No

  If yes, please describe:

  _____
  _____

- Have you had any serious illnesses that required hospitalization?
  - ❑ Yes ❑ No

  If yes, please describe:

  _____
  _____

- Have you had any surgeries?
  - ❑ Yes ❑ No

  If yes, please list the type of surgery and the date of the surgery:

  _____
  _____

- Have you had any nervous or mental illnesses?
  ❑ Yes ❑ No

- Have you had psychiatric care?
  ❑ Yes ❑ No

- Have you received a medical discharge from the Armed Forces?
  ❑ Yes ❑ No

- Have you returned to work since your accident?
  ❑ Yes ❑ No
  If yes, please fill out the information below:

Date	Employer	Occupation	Light/Regular Duty	Full-time/ Part-time

Current Medical Complaints

Back Pain

- Currently, 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/numbness in my:
  ❑ Right leg ❑ Left leg ❑ Both
- My pain is worse when I:
  ❑ Cough/sneeze ❑ Walk ❑ Pull
  ❑ Sit ❑ Lift
  ❑ Bend ❑ Push
- My back is worse with sexual activity:
  ❑ Yes ❑ No
- My pain wakes me up during the night:
  ❑ Yes ❑ No
- Changes in the weather affect my pain:
  ❑ Yes ❑ No

Neck Pain

- My neck 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/numbness in my:
  - ❑ Right arm ❑ Left arm ❑ Both
- My pain is worse when I:
  - ❑ Cough/sneeze ❑ Push ❑ Lift
  - ❑ Bend forward ❑ Pull ❑ Turn my head
- My pain wakes me up during the night:
  - ❑ Yes ❑ No
- Changes in the weather affect my pain:
  - ❑ Yes ❑ No
- I have stiffness:
  - ❑ Yes ❑ No
- I have headaches:
  - ❑ Yes ❑ No
- If I do get headaches, they occur:
  - ❑ Sometimes ❑ All of the time

Other Pain

Please describe any current medical complaints which you are experiencing and that were not previously covered on this questionnaire; or, list any additional comments that you wish to make regarding your condition:

_____

_____

_____

Job Description

In terms of an 8 hour workday, "occasional" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day:

- In a typical 8 hour workday, I:
  - Sit: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 hours
  - Stand: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 hours
  - Walk: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 hours
- On the job, I perform the following activities:
  - Bend/stoop: ❑ Not at all ❑ Occasionally ❑ Frequently ❑ Continuously
  - Squat: ❑ Not at all ❑ Occasionally ❑ Frequently ❑ Continuously
  - Crawl: ❑ Not at all ❑ Occasionally ❑ Frequently ❑ Continuously
  - Climb: ❑ Not at all ❑ Occasionally ❑ Frequently ❑ Continuously
  - Reach above shoulder level: ❑ Not at all ❑ Occasionally ❑ Frequently ❑ Continuously
  - Crouch: ❑ Not at all ❑ Occasionally ❑ Frequently ❑ Continuously
  - Kneel: ❑ Not at all ❑ Occasionally ❑ Frequently ❑ Continuously
  - Balancing: ❑ Not at all ❑ Occasionally ❑ Frequently ❑ Continuously
  - Pushing/pulling: ❑ Not at all ❑ Occasionally ❑ Frequently ❑ Continuously

- On the job, I lift:
  - Up to 10 pounds: ❑ Not at all ❑ Occasionally ❑ Frequently ❑ Continuously
  - 11-24 pounds: ❑ Not at all ❑ Occasionally ❑ Frequently ❑ Continuously
  - 25-34 pounds: ❑ Not at all ❑ Occasionally ❑ Frequently ❑ Continuously
  - 35-50 pounds: ❑ Not at all ❑ Occasionally ❑ Frequently ❑ Continuously
  - 51-74 pounds: ❑ Not at all ❑ Occasionally ❑ Frequently ❑ Continuously
  - 75-100 pounds: ❑ Not at all ❑ Occasionally ❑ Frequently ❑ Continuously

- Do you have to bend over while doing lifting?
  ❑ Yes ❑ No
- Are your feet ever used for repetitive movements, such as in operating foot controls?
  ❑ Yes ❑ No
- Do you use your hands for repetitive actions, such as:
  - Simple grasping: ❑ Right hand ❑ Left hand ❑ Both ❑ N/A
  - Firm grasping: ❑ Right hand ❑ Left hand ❑ Both ❑ N/A
  - Fine manipulating: ❑ Right hand ❑ Left hand ❑ Both ❑ N/A

- Are you required to work on unprotected heights?
  ❑ Yes ❑ No
  If yes, describe:
  _____
  _____

- Are you required to be around moving machinery?
  ❑ Yes ❑ No
  If yes, describe:
  _____
  _____

- Are you exposed to marked changes in temperature and humidity?
  ❑ Yes ❑ No
  If yes, describe:
  _____
  _____

- Are you required to drive automotive equipment?
  ❑ Yes ❑ No
  If yes, describe:
  _____
  _____

- Are you exposed to dust, fumes, and/or gases?
  ❑ Yes ❑ No
  If yes, describe:
  _____
  _____

- Please list any additional comments:
  _____
  _____
  _____

Signature: _____ **Date:** _____ / _____ / _____