ANNAPOLIS FAMILY CHIROPRACTIC
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WORKER'S COMPENSATION HEALTH QUESTIONNAIRE

Job Description Date:_____/_____/_____

Last Name _____First Name_____Middle Initial_____

Date of Accident:_____/_____/_____ Time of Accident:____:____ AM / PM

Describe your job duties: _____

_____

On the job I perform the following activities: (Circle as many as apply)

Bend/Stoop	Squat	Climb	Reach above shoulders
Crouch	Kneel	Push/Pull	Maintain awkward posture

On the job I regularly lift between:

1-10 lbs. 11-24 lbs. 25-34 lbs. 35-50 lbs. 51-74 lbs. 75-100 lbs.

Do you use your hands for repetitive movements such as: (Circle as many as apply)

Simple Grasping (left hand)	Firm Grasping (left hand)
Simple Grasping (right hand)	Firm Grasping (right hand)

In terms of an 8 hour workday I: (Circle number of hours for each activity)

Sit… 1 2 3 4 5 6 7 8 hours

Stand… 1 2 3 4 5 6 7 8 hours

Walk… 1 2 3 4 5 6 7 8 hours

How long have you been working there? _____

What is your work schedule? _____

Do you push or pull carts, dollies, or other objects? Yes No

In your own words, please describe the accident? _____

_____

_____

_____

_____

Did you finish what you were doing? Yes No

To whom did you report the accident? _____

History of Injury

Did you fill out a work injury report form? Yes No Did you get a copy? Yes No

Have you been off work at any time since the injury? Yes No

If yes, when? _____

Have you been treated by another doctor for this accident? Yes No

If yes, please list doctor's name and address:

_____

_____

What type of treatment did you receive? _____

How long were you treated by this doctor? _____

Are you… Improved Unchanged Getting worse

If you are taking medications, what type are you taking?

_____

_____

Do these medications help? Yes No Don't know

Have you had physical therapy? Yes No

If yes, how often?

Daily Every other day Several times a week Monthly

Other _____

Did you go back to work after the injury? Yes No

If yes, were you doing the same job as usual? Yes No

Any restrictions?_____

What happened with your symptoms when you went back to work?

_____

_____

Attorney Information

Have you contacted an attorney about the injury? Yes No *(if no, proceed to Present Complaints)*

Please give name and address:

_____

_____

When did you first consult with an attorney?_____

Has he/she filed a Worker's Compensation lawsuit? Yes No

Do you have a case/lawsuit pending with anyone other than your employer? (e.g. other driver, product liability, etc.) _____

_____

Who referred you to this attorney?

_____

Present Complaints

Do you have pain? Yes No

If yes, where is your pain? _____

Does your present pain travel? Yes No

How frequently does pain occur? Sometimes All the time

My pain is worse when I:

Cough or sneeze Sit Lift Bend Walk Push Pull

What activity or position makes the pain better? _____

_____

Is there… (circle all that apply)

Stiffness Numbness Tingling Weakness Swelling Grinding Locking

Is there any deformity/scars? _____

My pain wakes me up during the night? Yes No

Changes in the weather affect my pain? Yes No

Prior to this accident, have you ever had any of the physical complaints similar to what you have now? Yes No Don't know

If yes, describe:

_____

_____

_____

_____