

WORK-RELATED QUESTIONNAIRE

Patient Name: _____ Date of injury: _____ Time ____ a/p

Employer at the time of injury: _____ Phone: _____

Address: _____ City _____ State _____ Zip: _____

Job Title: _____ Length of time working prior to accident: _____

Last date worked for this employer: _____

Type of work being performed at the time of injury: _____

Describe the injury/accident: _____

What area of your body was injured? _____

When did the pain start? _____

Was the pain intense or gradually worsened or gradually improve? _____

Describe anything environmentally that may have contributed to your present injury: Darkness, slippery floor, limited space, etc.: _____

List and describe any additional injuries/accidents: _____

Are you currently working? Y N If no, why not? _____

Disability:

Have you lost any time **due to this injury**? N Y: Dates: _____

If on disability (time loss), do you want to go back to work doing your regular job duties? Y N

If no, state why you don't want to go back to regular job duties: _____

If you have gone back to work, list activities that are painful and/or difficult: _____

Current employer if different: _____

Job duties: _____ Hours per week _____

Restrictions? N Y: List: _____

Treatment:

Were you hospitalized, taken to a clinic or see the company nurse immediately after this injury? N Y:

Who: _____ Where: _____

Treatment given: _____

Results of treatment: _____ Last date of treatment: _____

Other doctors seen in addition to Dr. Royer:

Who: _____ Where: _____

Treatment given: _____

Results of treatment: _____ Last date of treatment: _____

Who: _____ Where: _____

Treatment given: _____

Results of treatment: _____ Last date of treatment: _____

Harmony Chiropractic Center, Inc.

3829 Woodley Road; Suite 1 • Toledo, OH 43606

419-517-5055

Prior Similar Symptoms:

Have you ever had similar complaints to this region of the body? N Y: Describe: _____

Type of treatment sought for this condition: _____

Any diagnostic testing (Xrays, CT, etc) for this condition? N Y: What: _____

Were you receiving ongoing care for this condition prior to this injury?

Y: Type of care: _____ Treatment schedule _____

N: Last visit: _____ Any residual disabilities: N Y: _____

When was the last time you felt pain from this condition? _____

Reporting of Injury:

What date did you report this injury? _____ To whom: _____

Their position: _____ Was a report filed? _____

Are they aware you are seeking care? N Y

Previous work related claims:

Area injured: _____

Claim Number: _____ Employer: _____

Diagnoses: _____

Still receiving treatment? N Y: From who: _____

Have you had a permanent partial award for this claim? N Y: How much? _____

Area injured: _____

Claim Number: _____ Employer: _____

Diagnoses: _____

Still receiving treatment? N Y: From who: _____

Have you had a permanent partial award for this claim? N Y: How much? _____

Is there anything that you feel is or will complicate your response to care? _____

What activities were you able to do before this injury that you are not able to perform now?

Are you on a home exercise program now? N Y: Describe _____

How frequent do you perform this program? _____ Does it help? _____

Do you have a TENs unit? Y N

Do you have a lower back support? Y N

Do you have orthotics for your shoes? Y N

Are you interested in nutritional support? Y N

Physical Limitation

On the job I lift/carry	None	1x/hour	up to 15x/hour	up to 60x/hour	60+x/hour
Up to 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-25	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26-50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51-75	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
76-100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching					
About shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Below shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In a typical 8 hour work day, how many hours do you
sit _____ stand _____ walk _____?

Do you do repetitive lifting? Y N

Do you do repetitive bending? Y N

Do you use your feet for repetitive movements, such as foot controls? Y N

Do your hands perform repetitive actions such as:

 Simple grasping Y N

 Firm grasping Y N

 Fine manipulation Y N