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: _____

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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

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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	☐	☐	☐	☐	☐
11-25	☐	☐	☐	☐	☐
26-50	☐	☐	☐	☐	☐
51-75	☐	☐	☐	☐	☐
76-100	☐	☐	☐	☐	☐
Bending	☐	☐	☐	☐	☐
Crawling	☐	☐	☐	☐	☐
Crouching	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	☐
Pushing	☐	☐	☐	☐	☐
Pulling	☐	☐	☐	☐	☐
Reaching					
About shoulder level	☐	☐	☐	☐	☐
At shoulder level	☐	☐	☐	☐	☐
Below shoulder level	☐	☐	☐	☐	☐

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