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 Injury:_____
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 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

RISK FACTOR ASSESSMENT QUESTIONNAIRE - INITIAL

Patient Name _____ Date _____

Instructions: Please answer every section, and mark in each section the ONE CHOICE which applies to you.

1. Where do you have pain? Check all appropriate sites.
   ( ) Neck ( ) Shoulders ( ) Upper back ( ) Lower Back ( ) Leg
2. How long ago did your current episode begin?
   ( ) Less than 2 weeks ago ( ) 2 weeks to < 8 weeks ago ( ) 8 weeks to < 3 months ago ( ) 3 months to < six months ago ( ) > 6 months ago
3. How many previous episodes required treatment?
   ( ) None ( ) 1 ( ) 2 ( ) 3 ( ) 4 or more
4. Have you been hospitalized or had surgery for the same or similar complaint before? ( ) Yes ( ) No
5. Please indicate your usual level of pain during the past week.
   No pain _____ worst possible pain
   0 1 2 3 4 5 6 7 8 9 10
6. How often would you say that you have experienced pain episodes, on average during the past 3 months? (Circle one number)
   Never _____ Always
   0 1 2 3 4 5 6 7 8 9 10
7. Does pain, numbness, tingling or weakness extend into your leg (from the low back) and/or arm (from the neck)?
   None of the time _____ All of the time
   0 1 2 3 4 5 6 7 8 9 10
8. During the last week, how often have you taken medication (such as aspirin, Motrin, Tylenol, or prescription medication) for your pain complaint?
   Not at all _____ 3 or more times a day
   0 1 2 3 4 5 6 7 8 9 10
9. If you had to spend the rest of your life with your condition as it is right now, how would you feel about it?
   Delighted _____ Terrible
   0 1 2 3 4 5 6 7 8 9 10
10. How anxious (eg, tense, uptight, irritable, fearful, difficulty in concentrating/relaxing) have you been feeling during the past week?
    Not at all _____ Extremely anxious
    0 1 2 3 4 5 6 7 8 9 10
11. How much have you been able to control (eg, reduce/help) your pain/complaint on your own during the past week?
    I can reduce it _____ I can't reduce it at all
    0 1 2 3 4 5 6 7 8 9 10
12. Please indicate how depressed (eg, down in the dumps, sad, downhearted, in low spirits, pessimistic, feelings of hopelessness) you have been feeling in the past week.
    Not depressed at all _____ Extremely depressed
    0 1 2 3 4 5 6 7 8 9 10
13. How would you rate your general health?
    Poor _____ Excellent
    0 1 2 3 4 5 6 7 8 9 10
14. Do you smoke tobacco a pack a day or more? ( ) Yes ( ) No
15. An increase in pain is an indication that I should stop what I am doing until the pain decreased.
    Completely agree _____ Completely disagree
    0 1 2 3 4 5 6 7 8 9 10
16. Physical activity makes my pain worse?
    Completely disagree _____ Completely agree
    0 1 2 3 4 5 6 7 8 9 10
17. I can do light work for an hour?
    Can't do it because of pain problems Can do it without pain being a problem
    _____
    0 1 2 3 4 5 6 7 8 9 10
18. I can sleep at night.
    Can't do it because of pain problems Can do it without pain being a problem
    _____
    0 1 2 3 4 5 6 7 8 9 10
19. How physically demanding is your job (include housework if not employed outside the home)?
    Not at all demanding _____ Very demanding
    0 1 2 3 4 5 6 7 8 9 10
20. Have you been disabled due to the same or similar pain/complaint in the last 12 months? ( ) Yes ( ) No
21. I should not do my normal work with my present pain.
    Completely disagree _____ Completely agree
    0 1 2 3 4 5 6 7 8 9 10
22. How well do you like your work?
    Not at all _____ Very much
    0 1 2 3 4 5 6 7 8 9 10
23. What kind of trouble at work do you think you will have sitting or standing 6 weeks from now?
    No trouble _____ Extreme trouble
    0 1 2 3 4 5 6 7 8 9 10
24. On a scale of 0 to 10, how certain are you that you will be working in 6 months?
    Very certain _____ Not certain at all
    0 1 2 3 4 5 6 7 8 9 10