TORMAN CHIROPRACTIC GROUP

WORKER'S COMPENSATION INJURY QUESTIONNAIRE

PLEASE PRINT:

Name:____ Todays Date:_______________

Employer's Business Name at time of Accident:____

Employer's Phone:__________________ Employer's Address________________________________

Occupation:____
❑Yes ❑No Previous Worker's Compensation Injury? Impairment Rating: ______________________

Length of time at this job prior to injury:____
Date of Injury:_________________ Time of injury:_______________ Last Date Worked: __________________

Please explain what you were doing at the time you were injured and how the accident happened (lifting, bending, walking, carrying standing, etc.) ____

____

When did the pain begin?(please be specific) ____

Where did you first feel it?(please be specifi ____

Was the pain intense at first or did it gradually worsen? ______________________________

REPORT ACCIDENT/ACCIDENT OBSERVER

What date did you report this injury on?____

Who did you report this injury to?____________________Position? ____________________

Did anyone else observe accident/injury? ❑Yes ❑No If yes, Name: ______________________
Position:______________________

SYMPTOMS FROM ACCIDENT

Did you experience bleeding cuts or bruises? ❑Yes ❑No
If bleeding cuts where?____________________ If bruises, where?____________________

Please describe how you felt. PLEASE BE SPECIFIC.
Immediately after the accident:____

Later that ❑Day ❑Night:____

The next day(s):____

____

Check symptoms that have become apparent since the accident/injury:

❑Nervousness
❑Neck Pain/Stiffness
❑Midback Pain
❑Low Back Pain
❑Eyes sensitive to light
❑Pain behind eyes
❑Dizziness
❑Cold sweats
❑Face flushed
❑Loss of balance
❑Loss of smell
❑Loss of taste
❑Loss of memory
❑Pins & Needles - Arms
❑Pins & Needles - Legs
❑Shortness of breath
❑Head seems too heavy
❑Irritability
❑Sleeping trouble
❑Toe Numbness
❑Finger Numbness
❑Cold Hands
❑Cold Feet
❑Chest Pain
❑Constipation
❑Diarrhea
❑Fatigue
❑Headache
❑Fainting
❑Anxiety
❑Seizures
❑Visualdisturbance
❑Forgetfulness
❑Blurred Vision
❑Double Vision
❑Confused

❑Ringing/Buzzing Ears ❑Depression ❑Tension ❑Disoriented
❑Fever ❑Other_________

MECHANISM OF INJURY:
Please explain the mechanism of the injury *(only fill in those sections that apply to you)*:

FALL:
❑Yes ❑No Did you hit anything when you fell? If yes, what?____

❑Yes ❑No Were you carrying anything when you fell? If yes, what?____
How much did it weigh?_______________lbs.
❑Yes ❑No Did you twist when you fell? If so, to which side? ❑Left ❑Right
❑Yes ❑No Was the area lighted?

Describe the condition of the area (slippery, graveled, etc.)____

What part of the body did you fall on?____

How far did you fall? (In feet) ____

What did you land on?____

LIFT/PULL:
How much did the object weigh?______________________lbs.
❑Yes ❑No Did you fall after the injury? If yes, how far?____

❑Yes ❑No Did you hit anything when you fell? If yes, what? ____
❑Yes ❑No Were you twisting when you were lifting/pulling? If yes, to which side? ❑Left ❑Right
How far off the ground did you have the object before the pain started
?_________________________________
❑Yes ❑No Did you drop the object when the pain started?
❑Yes ❑No Did it land on you? Where? ____

Did you lift with your: ❑Legs ❑Back ❑Other ____

BEND:
❑Yes ❑No Were you lifting when you were bent over? If yes, how much did the object weigh?___________lbs.

How far were you bent over?____

❑Yes ❑No Did you fall when the pain started? How far? ____
❑Yes ❑No Were you twisting when you bent forward? Toward which side? ❑Left ❑RighT

❑Yes ❑No Did you land on anything? If so, what?____

WORK STATUS HISTORY:
❑Yes ❑No Have you lost time from work as a result of this new injury?
If yes, please give
dates:____

❑Yes ❑No Have you gone back to work? When:____
If yes, status or work: ❑Modified ❑RegulaR

List restrictions you have been placed on:____
If you have gone back to work, list activities that are:
PAINFUL: ____

DIFFICULT: ____
❑Yes ❑No If you are currently on disability (time loss), do you want to go back to work doing your regular job?
If no, why not? ____
❑Yes ❑No Are there any problems you have with a fellow employee, supervisor, or manager that needs to be discussed?
If yes, please

explain:____

____

FIRST DOCTOR/HOSPITAL/CLINIC:

❑Yes ❑No Were you hospitalized as a result of this accident? If yes, where:________________________________

Doctor 1 Name:____Date of First Visit:________________________

❑Yes ❑No Were you examined? ❑Yes ❑No Were X-rays taken?

What diagnosis did the doctor give you?____

❑Yes ❑No Were you given treatment? If yes, what type?____

What benefits did you receive from this treatment?____

____

Date of last treatment?____

❑Yes ❑No Did the doctor refer you to another health professional?
If yes, to whom and for what?____

❑Yes ❑No Did you follow the doctor's recommendation?
If no, why not?____

SECOND DOCTOR/CLINIC:

Doctor 2 Name:_______________________________________Date of First Visit:________________________

❑Yes ❑No Were you examined? ❑Yes ❑No Were X-rays taken?

What diagnosis did the doctor give you?____

❑Yes ❑No Were you given treatment? If yes, what type?____

What benefits did you receive from this treatment?_______________________________________

____

Date of last treatment?____

PRIOR SIMILAR SYMPTOMS:

❑Yes ❑No Did you have any physical complaints just before the accident?
If yes, please describe in detail:____

____

❑Yes ❑No Have you ever had any prior injuries, accidents, diseases or treatment to the area of your body now affected?
If yes, what part was previously injured?____

Date previously
injured?____

Describe previous
injury:____

❑Yes ❑No Were you treated? By whom?____

Date treatment began:_____________________________Date treatment ended:______________________

The last date you felt pain or problems from that previous injury:___________________________________

JOB DESCRIPTION

In terms of an 8 - hour workday: ***Occasionally*** = 33%, ***Frequently*** = 34% to 66%, ***Continuously*** = 67% to 100%

In a typical 8 - hour workday, I (circle the number of hours of 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

On the job, I perform the following activities:

	Not at all	Occasionally	Frequently	Continuously
Bend/Stoop	❑	❑	❑	❑
Squat	❑	❑	❑	❑
Crawl	❑	❑	❑	❑
Climb	❑	❑	❑	❑
Reach Above	❑	❑	❑	❑
Shoulder Level	❑	❑	❑	❑
Crouch	❑	❑	❑	❑
Kneel	❑	❑	❑	❑
Balancing	❑	❑	❑	❑
Pulling/Pushing	❑	❑	❑	❑

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

❑Yes ❑No Are you required to bend over while doing any lifting?
❑Yes ❑No Are your feet used in repetitive movements, such as operating foot controls?

Do you use your hands for repetitive actions such as:

	Simple Grasping	Firm Grasping	Find Manipulating
Right Hand	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
Left Hand	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No

❑Yes ❑No Are you required to work at unprotected heights?
If yes, please describe:____

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

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

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

❑Yes ❑No Are you exposed to dust, flames, and/or gases?
If yes, please describe: ____

Please list any additional comments: ____

Patient's Signature:____**Date** :______________________________