WORK RELATED INJURY QUESTIONAIRRE

Patient Name: ______________________________ Date: ________ Acct. #: ________

Describe the accident: ____
____
____

Name of employer at time of injury: ________________________________

Do you still work for that employer? ☐ Yes ☐ No Date of injury: ______________

Have you missed any work due to your injury? ☐ Yes ☐ No

If yes, when was your last day worked? ____________________

Have you had any prior work injuries? ☐ Yes ☐ No, If yes when: ___________

Are you currently receiving workers compensation? ☐ Yes ☐ No

Have you ever received a prior workers compensation award? ☐ Yes ☐ No
If yes, please explain: ____

Your present job involves:

Sitting		Standing		Walking		Lifting		Driving	
	< 1 hour		< 1 hour		< 1 hour		< 1 hour		< 1 hour
	1-3 hours		1-3 hours		1-3 hours		1-3 hours		1-3 hours
	4-7 hours		4-7 hours		4-7 hours		4-7 hours		4-7 hours
	8-11 hours		8-11 hours		8-11 hours		8-11 hours		8-11 hours
	+ 12 hours		+ 12 hours		+ 12 hours		+ 12 hours		+ 12 hours

Typing		Using a mouse		Grasping		Crawling		Climbing	
	< 1 hour		< 1 hour		< 1 hour		< 1 hour		< 1 hour
	1-3 hours		1-3 hours		1-3 hours		1-3 hours		1-3 hours
	4-7 hours		4-7 hours		4-7 hours		4-7 hours		4-7 hours
	8-11 hours		8-11 hours		8-11 hours		8-11 hours		8-11 hours
	+ 12 hours		+ 12 hours		+ 12 hours		+ 12 hours		+ 12 hours

☐ Repetitive motion ☐ Fine manipulation, pushing, pulling, or torquing with hands

Are you experiencing any limitations of working because of your injury?

☐ Cannot turn neck
☐ Cannot bend neck
☐ Cannot turn back
☐ Cannot bend back
☐ Cannot use left arm
☐ Cannot use right arm
☐ Cannot use left leg
☐ Cannot use right leg
☐ Pain limits amount of movement

☐ Cannot use knee due to pain and discomfort
☐ Cannot drive due to pain.
☐ Cannot stand due to pain
☐ Cannot sit due to pain
☐ Cannot walk due to pain
☐ Increased fatigue
☐ Unable to lift more than 10lbs
☐ Unable to lift more than 15-20lbs

☐ Unable to lift more than 20-25lbs
☐ Unable to lift more than 50lbs
☐ Inability to carry out normal work duties without pain and discomfort
☐ Inability to carry out activities of daily living without pain and discomfort.

Patient Name: ______________________________ Date: ________ Acct. #: ________

How many rest breaks do you receive?

☐ No breaks
☐ A lunch break only
☐ A lunch break and 1 rest break
☐ A lunch break and 2 rest breaks
☐ A lunch break and 3 rest breaks
☐ A lunch break and 4 rest breaks

What type of surface do you work on?

☐ Asphalt
☐ Grass
☐ Gravel
☐ Dirt
☐ Carpet
☐ Mud
☐ Wood
☐ Pavement
☐ Hard floors (Indoor)

Are you exposed to:

☐ Dust
☐ Gas
☐ Fumes
☐ Vapors
☐ Chemicals
☐ Loud noises
☐ Extreme heat
☐ Extreme cold
☐ Extreme humidity

Are you required to:

☐ Work at heights ☐ Drive a vehicle. ☐ Walk on uneven ground ☐ Work near hazardous equipment

Are you pressured for speed, performance or perfection?

☐ Constantly ☐ Frequently ☐ Often ☐ Occasionally ☐ Almost never

% of work day indoors:

☐ 100 ☐ 90 ☐ 80 ☐ 70 ☐ 60 ☐ 50 ☐ 40 ☐ 30 ☐ 20 ☐ 10 ☐ 0

% of work day outdoors:

☐ 100 ☐ 90 ☐ 80 ☐ 70 ☐ 60 ☐ 50 ☐ 40 ☐ 30 ☐ 20 ☐ 10 ☐ 0

Have you ever been fired or laid off? ☐ Fired ☐ Layed off ☐ Both fired and layed off

Additional comments: ____

____

____