Worker's Compensation Injury Questionnaire

Please Print

Name:_____ Today's Date:_____

Employer's Business Name at time of Accident:_____

Employer's Phone:_____ Employer's Address:_____

Occupation:_____ Impairment Rating:_____
Previous Worker's Compensation Injury? □ Yes □ No

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, walking, carrying standing, etc) _____
_____

When did the pain begin? (Please be specific) _____

When did you first feel it? (Please be specific) _____

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 or 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 been apparent since the accident/injury

□ Nervousness	□ Loss of balance	□ Sleeping Trouble	□ Headache	□ Fainting
□ Neck Pain/Stiffness	□ Loss of smell	□ Toe Numbness	□ Anxiety	□ Seizures
□ Ringing/buzzing ears	□ Loss of taste	□ Finger Numbness	□ Cold Hands	□ Cold Feet
□ Low Back Pain	□ Loss of memory	□ Blurred Vision	□ Chest Pain	□ Constipation
□ Eyes- light sensitive	□ Pins/Needles –Arms	□ Diarrhea	□ Fatigue	□ Depression
□ Pain behind eyes	□ Pins/Needles – Legs	□ Dizziness	□ Confused	□ Disoriented
□ Shortness of breath	□ Double Vision	□ Forgetfulness	□ Tension	□ Cold Sweats
□ Heads seems heavy	□ Mid back Pain	□ Face Flushed	□ Irritability	□ Fever
□ Visual Disturbance	□ Other: _____			

MECHANISM OF INJURY:

Pleases explain the mechanism of the injury (only fill in the 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 your □ Legs □ Back Other _____

BEND:

□ Yes □ No Were you lifting when you bent over? If yes, how much did the object weigh? _____ lbs
How far did you bend 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, give dates: _____
_____
□ Yes □ No Have you gone back to work? When? _____
If yes, status of work: □ Modified □ Regular
List restrictions that you have been placed on: _____
If you have gone back to work, list the 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: _____
_____