

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

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

MECHANISM OF INJURY:

Please 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: _____