

# WORKERS' COMPENSATION PATIENT QUESTIONNAIRE

Dear Patient/Injured Worker:

It is important in a workers' compensation case to establish a complete and accurate base of personal and historical information. This information often becomes a critical part of the decision making process in coming to final determinations or conclusions about your case. Therefore, **your help and cooperation in answering this questionnaire as completely and accurately as possible is necessary and appreciated.** This is very important to the people involved in handling your case and for you to receive appropriate and fair compensation.

**PLEASE, REVIEW AND COMPLETE THIS PATIENT QUESTIONNAIRE. DOING THIS, WILL SIGNIFICANTLY REDUCE YOUR TIME IN THE OFFICE. THE AMOUNT OF TIME, WHICH HAS BEEN SCHEDULED FOR YOUR APPOINTMENT, DOES TAKE INTO CONSIDERATION THAT THIS HAS BEEN DONE. THANK YOU VERY MUCH!**

## PHYSICIAN USE ONLY:

Evaluation Date: \_\_\_\_\_  
Evaluation Began: \_\_\_\_\_ A.M. \_\_\_\_\_ P.M. \_\_\_\_\_  
Evaluation Ended: \_\_\_\_\_ A.M. \_\_\_\_\_ P.M. \_\_\_\_\_

**Employee Information:**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Address: (complete mailing address) \_\_\_\_\_

Phone No.: (\_\_\_\_) \_\_\_\_\_ Date Of Birth: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_

\_\_ Male \_\_ Female \* \_\_ Right Handed \_\_ Left Handed \_\_ Both \* Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Employer Information: (Your Employer At The Time You Were Injured)**

Name Of Business: \_\_\_\_\_ Phone No.: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

**Workers' Compensation Insurance Carrier Information:**

Name: \_\_\_\_\_ Phone No.: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Claims Representative: \_\_\_\_\_ Fax No.: (\_\_\_\_) \_\_\_\_\_

Claim No.: \_\_\_\_\_

**Information About Your Work Injury:**

Date Of Injury: \_\_\_\_\_ Time The Injury Occurred: \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

Date You Reported Your Injury To Your Employer/Supervisor: \_\_\_\_\_

Name Of Person You Reported Your Injury To: \_\_\_\_\_

Where Did Your Injury Occur? (Address Or Description Of Location): \_\_\_\_\_

\_\_\_\_\_

**Attorney Information: ( ) Check If None**

Name: \_\_\_\_\_ Phone No.: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

**HISTORY OF THE INJURY:**

Please Describe How Your Work Injury Occurred: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please List The Injured Body Parts, As A Result Of Your Work Injury:

\_\_\_\_\_

**(History Of The Injury - continued)**

How Did Your Symptoms Come On? \_\_\_ Suddenly \_\_\_ Gradually **If 'Gradually',** Over What Period of Time? \_\_\_\_\_

\_\_\_\_\_

When Did You Realize/Know That You Were Injured? Explain: \_\_\_\_\_

\_\_\_\_\_

**HISTORY OF TREATMENT:**

When Did You First Seek Treatment For Your Injury? Date: \_\_\_\_\_

Did Your Employer Send You For Treatment? \_\_\_ YES \_\_\_ NO

Did You Seek Treatment On Your Own? \_\_\_ YES \_\_\_ NO

**'INITIALLY', Did You Go To A Hospital/Emergency Room?** \_\_\_ YES \_\_\_ NO **If 'YES',**

Answer The Questions Below. **If 'NO',** Go To The ***Name Of Doctor/Facility #1*** On This Page.

Name Of Hospital/ER? \_\_\_\_\_ City: \_\_\_\_\_

Were You Admitted To The Hospital? \_\_\_ YES \_\_\_ NO If 'YES', How Long? \_\_\_\_\_

Name Of Doctor(s) At The Hospital/ER Who Treated You? \_\_\_\_\_

Describe The Type Of Treatment &/Or Diagnostic Testing That Was Done: \_\_\_\_\_

\_\_\_\_\_

What Did The Hospital Doctor(s) Say Was Wrong With You? \_\_\_\_\_

Were You Told That You Would Need More Treatment? \_\_\_ YES \_\_\_ NO If 'YES', Explain: \_\_\_\_\_

Did The Doctor(s) Restrict Or Modify Your Work Activit \_\_\_ NO If 'YES', How? \_\_\_\_\_

\_\_\_\_\_

Please list **ALL** Doctors You Have Seen Regarding Your Work Injury. Please List Them In Chronological Order/**The Order You Saw Them In:**

**Name Of Doctor/Facility #1:** \_\_\_\_\_ **City/Location:** \_\_\_\_\_

**Type Of Doctor** (degree or specialty): \_\_\_\_\_

**Describe Treatment And/Or Tests:** \_\_\_\_\_

\_\_\_\_\_

What Did This Doctor Say Was Wrong With You? \_\_\_\_\_

\_\_\_\_\_

**Date When Treatment Started:** \_\_\_\_\_ **Date When Treatment Stopped:** \_\_\_\_\_

**How Many Treatments/Visits Were There?** \_\_\_\_\_ **How Long Were The Treatments?** \_\_\_\_\_

**What Was The Result/Outcome Of The Treatment?** \_\_\_\_\_

\_\_\_\_\_

**Still Treating With This Doctor?** \_\_\_ YES \_\_\_ NO **If 'YES', How Often?** \_\_\_\_\_

**Did This Doctor Take You Off Work?** \_\_\_ YES \_\_\_ NO **If 'YES', Give Dates:** \_\_\_\_\_

**(Dr. #1 – continued)**

Did This Doctor Restrict Or Modify Your Work Activities? \_\_\_ YES \_\_\_ NO If 'YES', How?

Did This Doctor Say You Would Need More Treatment? \_\_\_ YES \_\_\_ NO If 'YES', Explain:

Did This Doctor Refer You Anywhere Else? \_\_\_ YES \_\_\_ NO If 'YES', Where And Why?

**Name Of Doctor/Facility #2:** \_\_\_\_\_ City/Location: \_\_\_\_\_

Type Of Doctor (degree or specialty): \_\_\_\_\_

Describe Treatment And/Or Tests: \_\_\_\_\_

What Did This Doctor Say Was Wrong With You? \_\_\_\_\_

Date When Treatment Started: \_\_\_\_\_ Date When Treatment Stopped: \_\_\_\_\_

How Many Treatments/Visits Were There? \_\_\_\_\_ How Long Were The Treatments? \_\_\_\_\_

What Was The Result/Outcome Of The Treatment? \_\_\_\_\_

Still Treating With This Doctor? \_\_\_ YES \_\_\_ NO If 'YES', How Often? \_\_\_\_\_

Did This Doctor Take You Off Work? \_\_\_ YES \_\_\_ NO If 'YES', Give Dates: \_\_\_\_\_

Did This Doctor Restrict Or Modify Your Work Activities? \_\_\_ YES \_\_\_ NO If 'YES', How?

Did This Doctor Say You Would Need More Treatment? \_\_\_ YES \_\_\_ NO If 'YES', Explain:

Did This Doctor Refer You Anywhere Else? \_\_\_ YES \_\_\_ NO If 'YES', Where And Why?

**Name Of Doctor/Facility #3:** \_\_\_\_\_ City/Location: \_\_\_\_\_

Type Of Doctor (degree or specialty): \_\_\_\_\_

Describe Treatment And/Or Tests: \_\_\_\_\_

What Did This Doctor Say Was Wrong With You? \_\_\_\_\_

Date When Treatment Started: \_\_\_\_\_ Date When Treatment Stopped: \_\_\_\_\_

How Many Treatments/Visits Were There? \_\_\_\_\_ How Long Were The Treatments? \_\_\_\_\_

What Was The Result/Outcome Of The Treatment? \_\_\_\_\_

Still Treating With This Doctor? \_\_\_ YES \_\_\_ NO If 'YES', How Often? \_\_\_\_\_

Did This Doctor Take You Off Work? \_\_\_ YES \_\_\_ NO If 'YES', Give Dates: \_\_\_\_\_

Did This Doctor Restrict Or Modify Your Work Activities? \_\_\_ YES \_\_\_ NO If 'YES', How?

Did This Doctor Say You Would Need More Treatment? \_\_\_ YES \_\_\_ NO If 'YES', Explain:

Did This Doctor Refer You Anywhere Else? \_\_\_ YES \_\_\_ NO If 'YES', Where And Why?

**(History Of Treatment – continued)**

**Name Of Doctor/Facility #4:** \_\_\_\_\_ City/Location: \_\_\_\_\_

Type Of Doctor (degree or specialty): \_\_\_\_\_

Describe Treatment And/Or Tests: \_\_\_\_\_

What Did This Doctor Say Was Wrong With You? \_\_\_\_\_

Date When Treatment Started: \_\_\_\_\_ Date When Treatment Stopped: \_\_\_\_\_

How Many Treatments/Visits Were There? \_\_\_\_\_ How Long Were The Treatments? \_\_\_\_\_

What Was The Result/Outcome Of The Treatment? \_\_\_\_\_

Still Treating With This Doctor? \_\_\_ YES \_\_\_ NO If 'YES', How Often? \_\_\_\_\_

Did This Doctor Take You Off Work? \_\_\_ YES \_\_\_ NO If 'YES', Give Dates: \_\_\_\_\_

Did This Doctor Restrict Or Modify Your Work Activities? \_\_\_ YES \_\_\_ NO If 'YES', How? \_\_\_\_\_

Did This Doctor Say You Would Need More Treatment? \_\_\_ YES \_\_\_ NO If 'YES', Explain: \_\_\_\_\_

Did This Doctor Refer You Anywhere Else? \_\_\_ YES \_\_\_ NO If 'YES', Where And Why? \_\_\_\_\_

**Name Of Doctor/Facility #5:** \_\_\_\_\_ City/Location: \_\_\_\_\_

Type Of Doctor (degree or specialty): \_\_\_\_\_

Describe Treatment And/Or Tests: \_\_\_\_\_

What Did This Doctor Say Was Wrong With You? \_\_\_\_\_

Date When Treatment Started: \_\_\_\_\_ Date When Treatment Stopped: \_\_\_\_\_

How Many Treatments/Visits Were There? \_\_\_\_\_ How Long Were The Treatments? \_\_\_\_\_

What Was The Result/Outcome Of The Treatment? \_\_\_\_\_

Still Treating With This Doctor? \_\_\_ YES \_\_\_ NO If 'YES', How Often? \_\_\_\_\_

Did This Doctor Take You Off Work? \_\_\_ YES \_\_\_ NO If 'YES', Give Dates: \_\_\_\_\_

Did This Doctor Restrict Or Modify Your Work Activities? \_\_\_ YES \_\_\_ NO If 'YES', How? \_\_\_\_\_

Did This Doctor Say You Would Need More Treatment? \_\_\_ YES \_\_\_ NO If 'YES', Explain: \_\_\_\_\_

Did This Doctor Refer You Anywhere Else? \_\_\_ YES \_\_\_ NO If 'YES', Where And Why? \_\_\_\_\_

Were Any Other Tests, Examinations, Treatments, or Therapy Done That Were Not Described Above? \_\_\_ YES \_\_\_ NO If 'YES', Please Describe What Was Done And What The Result Was: (use the back of this page if necessary): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**(History Of Other Injuries – continued)**

Have You Ever Had A **PRIOR**, Work Injury(ies)? \_\_\_ YES \_\_\_ NO If 'YES', Please Explain:

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Have You Ever Received a **PRIOR**, Workers' Compensation Disability Award? \_\_\_ YES \_\_\_ NO

If 'YES', Please Explain: \_\_\_\_\_

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Have You Ever Served In The **Military**? \_\_\_ YES \_\_\_ NO If 'YES', Did You Receive A Medical

Discharge? \_\_\_ YES \_\_\_ NO If 'YES', Please Explain Why: \_\_\_\_\_

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Have You Ever Had Any **PRIOR, NON-WORK RELATED INJURIES?** (e.g. Sprains/Strains, Slips/Falls, Motor Vehicle Accidents, Cumulative Or Repetitive Traumas, etc.) \_\_\_ YES \_\_\_ NO

If 'YES', Please Explain: \_\_\_\_\_

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Have You Had Any **NEW INJURIES** Involving Body Parts Which Are A Part Of Your Current

Work Injury? \_\_\_ YES \_\_\_ NO If 'YES', Please Explain: \_\_\_\_\_

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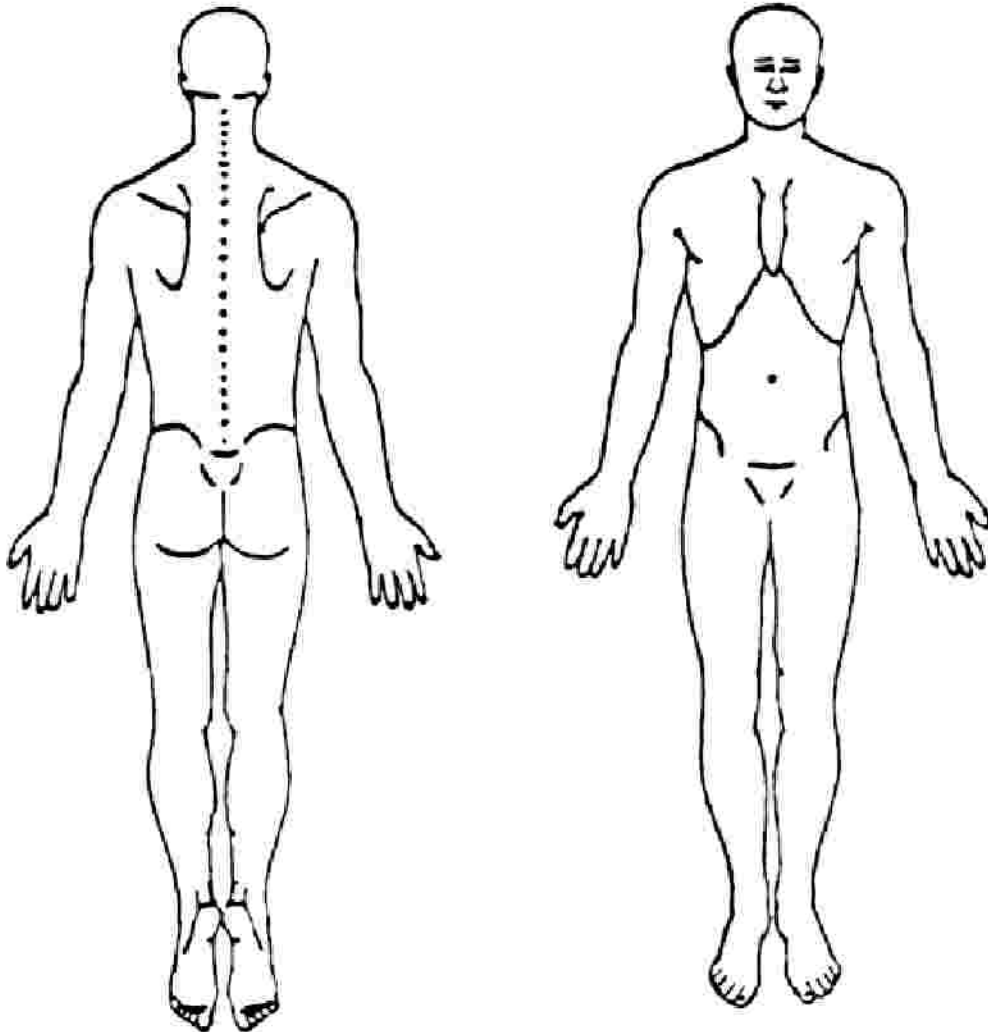
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## CURRENT SYMPTOMS:

Mark The Areas On Your Body Where You Are Having Symptoms From Your **Work Injury**(ies). Also, Review The Pain Scale On The Bottom Of This Page. The Doctor Will Be Asking You Questions.

**P** = Pain    **N** = Numbness/Tingling    **T** = Tenderness    **B** = Burning    **R** = Radiating



### **PAIN SCALE**

0-1	=	<b>Minimal</b>	=	The pain is an annoyance but does not stop me from working.
2-3	=	<b>Slight</b>	=	I can tolerate the pain but it causes some difficulty in doing my work. However, it does not stop me from working.
5	=	<b>Moderate</b>	=	The pain causes a marked handicap in my ability to work, but I can continue.
7-8	=	<b>Moderate To Severe</b>	=	The pain is approaching the worst I have ever experienced or could imagine. It causes a significant problem with working and most of the time I can't.
10	=	<b>Severe</b>	=	The pain is the worst I have ever experienced or could imagine and causes me to stop all work and activity.

**Please list your current symptoms/complaints resulting FROM YOUR WORK INJURY:**

**Complaint #1:** \_\_\_\_\_

What Percentage Of The Time Do You Experience/Feel This Symptom? \_ \_\_\_\_\_ %

What Activities Make This Symptom Worse? \_\_\_\_\_

What Makes This Symptom Better? \_\_\_\_\_

Can/Do You Have This Symptom Without Activity? \_\_\_\_\_

Pain Scale \_\_\_\_\_ 0 - 10. The Doctor Will Discuss This With You.

**Complaint #2:** \_\_\_\_\_

What Percentage Of The Time Do You Experience/Feel This Symptom? \_\_\_\_\_ %

What Activities Make This Symptom Worse? \_\_\_\_\_

What Makes This Symptom Better? \_\_\_\_\_

Can/Do You Have This Symptom Without Activity? \_\_\_\_\_

Pain Scale \_\_\_\_\_ 0 - 10. The Doctor Will Discuss This With You.

**Complaint #3:** \_\_\_\_\_

What Percentage Of The Time Do You Experience/Feel This Symptom? \_\_\_\_\_ %

What Activities Make This Symptom Worse? \_\_\_\_\_

What Makes This Symptom Better? \_\_\_\_\_

Can/Do You Have This Symptom Without Activity? \_\_\_\_\_

Pain Scale \_\_\_\_\_ 0 - 10. The Doctor Will Discuss This With You.

**Complaint #4:** \_\_\_\_\_

What Percentage Of The Time Do You Experience/Feel This Symptom? \_\_\_\_\_ %

What Activities Make This Symptom Worse? \_\_\_\_\_

What Makes This Symptom Better? \_\_\_\_\_

Can/Do You Have This Symptom Without Activity? \_\_\_\_\_

Pain Scale \_\_\_\_\_ 0 - 10. The Doctor Will Discuss This With You.

**Complaint #5:** \_\_\_\_\_

What Percentage Of The Time Do You Experience/Feel This Symptom? \_\_\_\_\_ %

What Activities Make This Symptom Worse? \_\_\_\_\_

What Makes This Symptom Better? \_\_\_\_\_

Can/Do You Have This Symptom Without Activity? \_\_\_\_\_

Pain Scale \_\_\_\_\_ 0 - 10. The Doctor Will Discuss This With You.

**(Current Symptoms - continued)**

Is There A Time Of Day That You Feel Worse? \_\_\_ YES \_\_\_ NO If 'YES', Please Explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In The Last **Two Months** Has Your Condition? \_\_\_ Stayed The Same \_\_\_ Improved \_\_\_ Worsened  
\_\_\_ Fluctuated But Overall Has Stayed About The Same

If Your Condition Has **Worsened**, Please Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

If Your Condition **Continues To Improve**, Please Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do You Feel That Your Condition Will Improve With Time? \_\_\_ YES \_\_\_ NO Please Explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Before This Work Injury, How Would You Describe Your Health? \_\_\_ Excellent \_\_\_ Good \_\_\_ Fair  
Or \_\_\_ Poor If 'Fair' Or 'Poor', Please Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**JOB DESCRIPTION:**

What Is Your Job Title? (**AT THE TIME OF YOUR INJURY**): \_\_\_\_\_

Describe The Nature Of Your Work: \_\_\_\_\_

When Did You Start Working For This Employer? \_\_\_\_\_

How Many Hours Per Day Do You Normally Work? \_\_\_\_\_

What Hours Do You Normally Work? \_\_\_\_\_

How Many Days Per Week Do You Work? \_\_\_\_\_ How Many Days In A Row? \_\_\_\_\_

How Long Is Your Lunch Break? \_\_\_\_\_ How Long Are Your Rest Breaks? \_\_\_\_\_

How Many Rest Breaks Do You Get In A Normal Work Shift? \_\_\_\_\_

What Percent Of Your Work Day Do You Work Indoors? \_\_\_ % Outdoors? \_\_\_ %

<b>At Work, How Many <u>Hours Per Day</u> Do You Do These Activities?</b>	___ Sit	___ Walk	___ Stand	___ Kneel
	___ Squat	___ Climb	___ Bend	___ Twist
	___ Reach	___ Crawl	___ Push	___ Pull
	___ Keyboard	___ Type	___ Mouse	___ Write
	___ Finger	___ Grasp		
	___ Work Overhead			

**Leave Blank If It Doesn't Apply.**

**If Done Continuously, Circle.** \_\_\_ Flex/Twist/Side-Bend/Extend Your Neck

**(Job Description – continued)**

**Please List Your Job Duties/Activities At Work: (WHEN YOU WERE INJURED)**

- A) \_\_\_\_\_
- B) \_\_\_\_\_
- C) \_\_\_\_\_
- D) \_\_\_\_\_
- E) \_\_\_\_\_
- F) \_\_\_\_\_
- G) \_\_\_\_\_

What Type Of Surface(s) Do You Work On? \_\_\_\_\_

Are You Required To **Lift At Work**? \_\_\_ YES \_\_\_ NO If 'YES', Please Answer The Following:

	<u>Objects Lifted</u>	<u>Weight In Pounds</u>	<u>Times Per Day</u>	<u>Distance Carried/Feet</u>
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____
3)	_____	_____	_____	_____
4)	_____	_____	_____	_____
5)	_____	_____	_____	_____

What Is the Heaviest Weight That You Are Required To Lift At Work? \_\_\_\_\_ P nds

Do You Have To Bend Over Or Lean Forward While Lifting? \_\_\_ YES \_\_\_ NO

Are You Able To Lift The Same Amount Of Weight Now, As Before The Injury? \_\_\_ YES \_\_\_ NO

**If 'NO', Please Explain What You Could Lift Before And What You Can Lift Now:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does Your Job Require You To Reach Below, Above Or At Shoulder Level? \_\_\_ YES \_\_\_ NO

If 'YES', Please Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are You Required To Move Your Feet In A Repetitive Movement/Activity? \_\_\_ YES \_\_\_ NO

If 'YES', Please Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are You Required To Use Your Hands For Fine Manipulation, Grasping, Pushing, Pulling, Torquing?

\_\_\_ YES \_\_\_ NO If 'YES', Please Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(Job Description – continued)**

Are You Exposed To Dust, Gas, Fumes, Vapors, Noise, Or Extreme Temperatures Or Humidity?

\_\_\_ YES \_\_\_ NO If 'YES', Please Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are You Required To Work At Heights Or Walk On Uneven Ground? \_\_\_ YES \_\_\_ NO If 'YES',  
Please Describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Are You Required to Drive Vehicles Or Work Near Hazardous Equipment? \_\_\_ YES \_\_\_ NO

If 'YES', Please Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do You Have Any Special Seeing/Visual Or Hearing Requirements? \_\_\_ YES \_\_\_ NO If 'YES',

Please Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are You Able To Perform Your Normal *Work Duties*? \_\_\_ YES \_\_\_ NO If 'NO', Please Explain

**What Activities You Can't Do, Or Have Difficulty Performing:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**WORK HISTORY:**

Did You Have **More Than One Employer When You Were Injured?** \_\_\_ YES \_\_\_ NO

If 'YES', Please List The Employer(s), And The Activities Required At That Employment?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If 'YES', Did The Other Employment/Activities Listed Above **Contribute To, Or Further Worsen**

**Your Condition?** \_\_\_ YES \_\_\_ NO If 'YES', Please Explain How? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(Work History – continued)**

Please List All Of **Your Previous Employers:** (i.e., Where You Have Worked Before The Job, Where Your Current Injury Occurred)

	<u>Employer</u>	<u>Dates Of Employment</u>	<u>Job Title/Duties</u>
A)	_____	_____	_____
B)	_____	_____	_____
C)	_____	_____	_____
D)	_____	_____	_____
E)	_____	_____	_____
F)	_____	_____	_____
G)	_____	_____	_____

Are You Still Working For The *Same Employer* Where Your Work Injury Occurred? \_\_\_ YES \_\_\_ NO  
**If 'NO',** Answer The Questions Below. **If 'YES',** Skip The Following Questions And Go To The Next Section Entitled **'PAST MEDICAL HISTORY.'**

Why Aren't You Working For The Same Employer Now? \_\_\_\_\_  
\_\_\_\_\_

When Did You Stop Working For The Same Employer? \_\_\_\_\_

If You Are Not Working For The Same Employer As When You Were Injured, **Please List Your Employment Since Leaving:** \_\_\_ I Have Not Worked Since Leaving That Employment

	<u>Employer</u>	<u>Dates Of Employment</u>	<u>Job Title/Duties</u>
A)	_____	_____	_____
B)	_____	_____	_____
C)	_____	_____	_____
D)	_____	_____	_____
E)	_____	_____	_____
F)	_____	_____	_____
G)	_____	_____	_____

Who Is Your **Current Employer(s)**? \_\_\_\_\_

Are You Doing The Same Type Of Work? \_\_\_ YES \_\_\_ NO

**If 'NO',** Describe The Type Of Work You Are Doing Now, Including Details On Physical Activity:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(Work History - continued)**

Has Any **NEW** Job Or Employment **Contributed To, Or Further Worsened Your Condition?**

YES  NO If 'YES', Please Name The Employer(s) And Explain How?

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Are You Going To Be **Retrained For Another Job/Occupation** As A Result Of This Work Injury?

YES  NO  I DO NOT KNOW  RECOMMENDED Please Describe:

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**PAST MEDICAL HISTORY:**

Please List **The Information About Your Medical History** In The Sections Below, With The **Approximate Dates**. If A Section Does Not Apply To You, Simply Mark An **(X)** In The 'Denied' Box:

Childhood Illnesses: ( ) Denied \_\_\_\_\_

Childhood Injuries: ( ) Denied \_\_\_\_\_

Allergies: ( ) Denied \_\_\_\_\_

Present Medications Taken (Prescription & Over-The-Counter): ( ) Denied \_\_\_\_\_

Surgeries: ( ) Denied \_\_\_\_\_

Hospitalizations: ( ) Denied \_\_\_\_\_

Adult Illnesses: ( ) Denied \_\_\_\_\_

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Doctor(s) Seen Previous To Your Current Work Injury: Name & Location/City: ( ) Denied \_\_\_\_\_

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**FAMILY HISTORY:**

List Any Health Problems In **Your Immediate Family**: (Mother, Father, Brother, Sister) ( ) Denied

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**REVIEW OF SYSTEMS:**

Please List Any Problems That You **Now Have** With The Following Body Systems:

Ears/Nose/Throat: ( ) Denied \_\_\_\_\_  
Eyes: ( ) Denied \_\_\_\_\_  
Lungs: ( ) Denied \_\_\_\_\_  
Liver: ( ) Denied \_\_\_\_\_  
G-I Tract (Stomach, Intestines, Bowels, Etc.): ( ) Denied \_\_\_\_\_  
Kidney/Bladder: ( ) Denied \_\_\_\_\_  
[Women] Reproductive System: ( ) Denied \_\_\_\_\_  
Skin: ( ) Denied \_\_\_\_\_  
Neurological: ( ) Denied \_\_\_\_\_  
Heart/Circulation: ( ) Denied \_\_\_\_\_  
Psychological: ( ) Denied \_\_\_\_\_

**OFF WORK ACTIVITIES:**

Do You Exercise? \_\_\_ YES \_\_\_ NO If 'YES', Please Describe Type & Frequency. If 'NO', Please Explain Why You Don't: \_\_\_\_\_

Do You Participate In Any Sports Activities? \_\_\_ YES \_\_\_ NO If 'YES', Please Describe Type & Frequency: \_\_\_\_\_

Do You Have Any Hobbies? \_\_\_ YES \_\_\_ NO If 'YES', Please Describe Type & Frequency: \_\_\_\_\_

Are You Able To Perform Your Normal/Regular Household Chores/Activities? \_\_\_ YES \_\_\_ NO If 'NO', Please Explain What You Cannot Do & Why: \_\_\_\_\_

**SOCIAL HISTORY:**

Are You? ( ) Married ( ) Single ( ) Separated ( ) Divorced ( ) Widowed

How Many Years Of Schooling Have You Had? \_\_\_\_\_

List Degrees, Diplomas, Licenses, Certifications You Hold: \_\_\_\_\_

Do You Use Alcohol? \_\_\_ YES \_\_\_ NO If 'YES', How Many Drinks Per Week? \_\_\_\_\_

Do You Use Tobacco? \_\_\_ YES \_\_\_ NO If 'YES', What Kind & Times Per Day Or Week? \_\_\_\_\_

Do You Use Drugs? \_\_\_ YES \_\_\_ NO If 'YES', What Kind & How Many Times Per Day Or Week? \_\_\_\_\_

List Any Other Habits, Describing Their Type & Frequency: \_\_\_\_\_

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE!



# PHYSICIAN USE ONLY

## ADDITIONAL HEADINGS/ISSUES IN THE REPORT

PHYSICAL EXAMINATION FINDINGS

DIAGNOSIS

DISCUSSION

PERMANENT AND STATIONARY STATUS

CAUSATION/ APPORTIONMENT

VOCATIONAL REHABILITATION

**FACTORS OF DISABILITY – Subjective/Objective/Work Preclusions (PD Report)**

**IMPAIRMENT RATING (Impairment Report)**

FUTURE MEDICAL CARE

COMPLIANCE STATEMENT

“I personally evaluated this patient and prepared this report. If others have performed any services in connection to this report, outside of medical preparation, their name and qualifications are noted herein. The time spent was in accordance with the DWC guidelines. I declare under of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provide to me and, except as noted herein, that I believe to be true. I have not violated Labor Code Section 139.3 and the contents of this report and bill is true and correct to the best of my knowledge. This statement is made under penalty of perjury.”

Signed in \_\_\_\_\_ County, CA by:

\_\_\_\_\_  
PHYSICIAN'S ORIGINAL SIGNATURE

\_\_\_\_\_  
DATE

Cc

Attachments: For State QMEs ONLY, Attach **IMC Form 111** & **DEU Forms 100 & 101**