

Worker's Compensation Questionnaire

Patient's Name _____ Date _____

Employer's Name _____

Employer's Address _____

Employer's City, State, Zip _____

Employer's Phone
Number _____

Date of Accident _____ Claim Number _____

Date reported to employer _____ Reported to ___ Whom _____

Occupation _____

Please describe how the injury occurred:

What were your symptoms following the accident?

When did the symptoms begin? _____ Immediately? _____ Day(s) Other _____

Did your employer send you to a doctor? _____ Were you hospitalized? _____

Have you been treated by any other doctor for this accident? _____ Yes _____ No

If yes, name of doctor(s) and phone number(s)

What medications are you currently taking?

Are you currently working? _____

Is there anything that you could do before the accident that you cannot do now? _____

Does the pain interrupt your sleep? _____ Yes _____ No Is the pain worse in the
_____ Morning _____ Afternoon _____ Night

Does your present position involve: _____ Lifting _____ sitting for long
period's _____ Repetitive Motion

Are your activities restricted due to the accident? _____ Yes _____ No

Since the accident, are your symptoms improving? _____ Yes _____ No