ORANGE PARK & ARGYLE CHIROPRACTIC CENTERS

WORK INJURY QUESTIONNAIRE

Date: _____ Email Address: _____

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: _____ Sex: _____ S.S. #: _____

Employer: _____ Employee Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Length of time with this employer prior to the accident: _____

Type of business: _____

Type of work being done at time of injury: _____

****

Date of injury: _____ Time: _____ Last day worked: _____

Are you currently at work? ( ) Yes ( ) No

Has your injury been reported to your employer? ( ) Yes ( ) No

Have you ever had an injury on the job before? ( ) Yes ( ) No

Where did the injury happen? _____

In your own words, please describe the accident: _____

_____

_____

_____

Have you seen another physician about this injury? ( ) Yes ( ) No

If yes, please list the physician's name and describe any treatment: _____

_____

_____

_____

Is your condition: ( ) Improving ( ) Getting Worse ( ) Same

Are you taking any medications for this injury? ( ) Yes ( ) No

If yes, list these medications and their results: _____

_____

_____

Have you had any physical therapy for this injury? ( ) Yes ( ) No

Did you suffer from any of your current symptoms prior to this accident? ( ) Yes ( ) No

If yes, please describe: _____

_____

_____

Have you ever had a serious illness or injury requiring hospitalization or serious medical care? ( ) Yes ( ) No

If yes, please describe: _____

_____

_____

CURRENT MEDICAL COMPLAINTS

BACK PAIN

1. Currently, I have pain in	( ) Low Back	( ) Mid Back	( ) Upper Back
2. My pain began	( ) Gradually	( ) Suddenly	
3. I have pain	( ) All the time	( ) Sometimes	
4. My pain goes into my	( ) Right leg	( ) Left leg	( ) Both legs
5. I have tingling/numbness in	( ) Right leg	( ) Left leg	( ) Both legs

6. My pain is worse when I:

Cough	( ) Yes ( ) No
Sit	( ) Yes ( ) No
Bend	( ) Yes ( ) No
Walk	( ) Yes ( ) No
Lift	( ) Yes ( ) No
Push	( ) Yes ( ) No
Pull	( ) Yes ( ) No

7. My pain keeps me from sleeping	( ) Yes ( ) No
8. Weather affects my pain	( ) Yes ( ) No

NECK PAIN

1. My pain began	( ) Gradually	( ) Suddenly	
2. I have pain	( ) All the time	( ) Sometimes	
3. My pain goes into my	( ) Right arm	( ) Left arm	( ) Both arms
4. I have tingling/numbness in	( ) Right arm	( ) Left arm	( ) Both arms

5. My pain is worse when I:

Cough/Sneeze	( ) Yes ( ) No
Bend Forward	( ) Yes ( ) No
Lift	( ) Yes ( ) No
Push	( ) Yes ( ) No
Pull	( ) Yes ( ) No
Turn My Head	( ) Yes ( ) No

6. My pain keeps me from sleeping	( ) Yes ( ) No
7. Weather affects my pain	( ) Yes ( ) No
8. I have neck stiffness	( ) Yes ( ) No
9. Headaches occur	( ) Yes ( ) No

If yes, describe and indicate how often? _____

OTHER PAIN

Please describe any current medical complaints which you are experiencing that were not previously covered on this questionnaire, or list any additional comments you wish to make regarding your condition:

_____

_____

_____

_____

JOB DESCRIPTION

In a typical 8-hour, how many hours are spent doing the following:

Sitting _____ Standing _____ Walking _____

On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend/Stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Reach above Shoulder Level	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Balancing	( )	( )	( )	( )
Pushing/Pulling	( )	( )	( )	( )

On the job, I lift:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Up to 10 lbs.	( )	( )	( )	( )
11 to 24 lbs.	( )	( )	( )	( )
25 to 34 lbs.	( )	( )	( )	( )
35 to 49 lbs.	( )	( )	( )	( )
50 to 74 lbs.	( )	( )	( )	( )
75 to 100 lbs.	( )	( )	( )	( )

Do you have to bend over while doing any lifting? ( ) Yes ( ) No

Are your feet used for repetitive movements, such as operating foot controls? ( ) Yes ( ) No

Do you use your hands for repetitive actions such as:

	SIMPLE GRASPING	FIRM GRASPING	FINE GRASPING
Right Hand	Yes ( ) No ( )	Yes ( ) No ( )	Yes ( ) No ( )
Left Hand	Yes ( ) No ( )	Yes ( ) No ( )	Yes ( ) No ( )

Are you exposed to marked changes in temperature and humidity? Yes ( ) No ( )

If yes, describe: _____

_____

Are you required to drive automotive equipment? Yes ( ) No ( )

If yes, describe: _____

_____

Are you exposed to dust, fumes, and/or gases? ( ) Yes ( ) No
If yes, describe: _____

_____

Please list any additional comments: _____

_____

_____

_____

_____

Signature: _____ Date: _____