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!

IF YOU NEED ADDITIONAL SPACE TO WRITE, PLEASE USE THE BACK OF THE PAGES.

PHYSICIAN USE ONLY:

Evaluation Date: _____
Evaluation Began: _____ A.M. ____ P.M. _____
Evaluation Ended: _____ A.M. ____ P.M. _____

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Richmond, CA 94806
Phone (510)758 -7462 * Fax (510) 758-7462

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: _____
Fax No.: (____) _____

HISTORY OF THE INJURY:

Please Describe How Your Work Injury Occurred: _____
_____
_____
_____
_____

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

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 Activities? ___ YES ___ 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): _____ Number Of Treatments/Visits? _____
Describe Treatment And/Or Tests: _____
What Did This Doctor Say Was Wrong With You? _____
Date When Treatment Started: _____ Date When Treatment Stopped: _____
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 Refer You Anywhere Else? ___ YES ___ NO If 'YES', Where And Why?
_____

Name Of Doctor/Facility #2: _____ City/Location:_____
Type Of Doctor (degree or specialty): _____ Number Of Treatments/Visits? _____
Describe Treatment And/Or Tests: _____
What Did This Doctor Say Was Wrong With You? _____
Date When Treatment Started: _____ Date When Treatment Stopped: _____
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 Refer You Anywhere Else? ___ YES ___ NO If 'YES', Where And Why?
_____

Name Of Doctor/Facility #3: _____ City/Location:_____

Type Of Doctor (degree or specialty): _____ Number Of Treatments/Visits? _____
Describe Treatment And/Or Tests: _____
What Did This Doctor Say Was Wrong With You? _____
Date When Treatment Started: _____ Date When Treatment Stopped: _____
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 Refer You Anywhere Else? ___ YES ___ NO If 'YES', Where And Why?
_____

Name Of Doctor/Facility #4: _____ City/Location:_____
Type Of Doctor (degree or specialty): _____ Number Of Treatments/Visits? _____
Describe Treatment And/Or Tests: _____
What Did This Doctor Say Was Wrong With You? _____
Date When Treatment Started: _____ Date When Treatment Stopped: _____
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 Refer You Anywhere Else? ___ YES ___ NO If 'YES', Where And Why?
_____

Name Of Doctor/Facility #5: _____ City/Location:_____
Type Of Doctor (degree or specialty): _____ Number Of Treatments/Visits? _____
Describe Treatment And/Or Tests: _____
What Did This Doctor Say Was Wrong With You? _____
Date When Treatment Started: _____ Date When Treatment Stopped: _____
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 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):** _____
_____
_____
_____
_____

Do You Treat Yourself? ___ YES ___ NO If 'YES', Please Explain How: _____
_____

(History Of Treatment – continued)

Are You Currently Taking Medication To Relieve The Effects Of This Injury? ___ YES ___ NO
If 'YES', Please Describe What You Take, (Prescription or Non-Prescription), How Much It Helps, How Often You Take It, Etc.: _____
_____

Are You Currently Using A Brace, Support, Cane, Crutch(es), Wheelchair, TENS Unit, Or Other Aid Because Of The Effects Of This Injury? ___ YES ___ NO If 'YES', Please Describe Type And How Often It Is Used: _____
_____

What Treatment(s) Offer You The Most Relief, And How Long Do The Benefits Last?
_____
_____

Have There Been Any Recommendations For Diagnostic Testing Or Treatment That You Have Not Received? If 'YES', What Was Recommended, And Who Recommended It?
_____
_____
_____

HISTORY OF OTHER INJURIES:

Have You Ever Experienced The Same Or Similar Symptoms/Problems ***BEFORE*** This Work Injury? ___ YES ___ NO If 'YES', Please Explain In Detail:
_____
_____
_____

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

Have You Ever Received a ***PRIOR,*** Workers' Compensation Disability Award? ___ YES ___ NO
If 'YES', Please Explain: _____
_____

Have You Ever Served In The **Military**? ___ YES ___ NO If 'YES', Did You Receive A Medical Discharge? ___ YES ___ NO If 'YES', Please Explain Why: _____
_____

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: _____
_____

Have You Had Any ***NEW INJURIES*** Since Your Current Work Injury Occurred? ___ YES ___ NO
If 'YES', Please Explain: _____
_____

ACTIVITIES OF DAILY LIVING/CURRENT COMPLAINTS:

1. Self-Care, Personal Hygiene: (**Example** – *Urinating, Defecating, Brushing Teeth, Combing Hair, Bathing, Dressing Oneself, Eating*)
2. Communication: (**Example** – *Writing, Typing, Seeing, Hearing, Speaking*)
3. Physical Activity: (**Example** – *Standing, Sitting, Reclining, Walking, Climbing Stairs*)
4. Sensory Function: (**Example** – *Hearing, Seeing, Tactile Feeling, Tasting, Smelling*)
5. Nonspecialized Hand Activities: (**Example** – *Grasping, Lifting, Tactile Discrimination*)
6. Travel: (**Example** – *Riding, Driving, Flying*)
7. Sexual Function: (**Example** – *Orgasm, Ejaculation, Lubrication, Erection*)
8. Sleep: (**Example** – *Restful, Nocturnal Sleep Pattern*)

Please Indicate Below, Limitations Or Difficulties You Have With Any Of The Above Activities.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

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

Complaint #1: _____
____ % Of Time Felt? 0-10 Pain Scale _____? Symptoms Without Activity? ___ YES ___ NO
What Activities Make This Symptom Worse? _____
What Makes This Symptom Better? _____

Complaint #2: _____
____ % Of Time Felt? 0-10 Pain Scale _____? Symptoms Without Activity? ___ YES ___ NO
What Activities Make This Symptom Worse? _____
What Makes This Symptom Better? _____

Complaint #3: _____
____ % Of Time Felt? 0-10 Pain Scale _____? Symptoms Without Activity? ___ YES ___ NO
What Activities Make This Symptom Worse? _____
What Makes This Symptom Better? _____

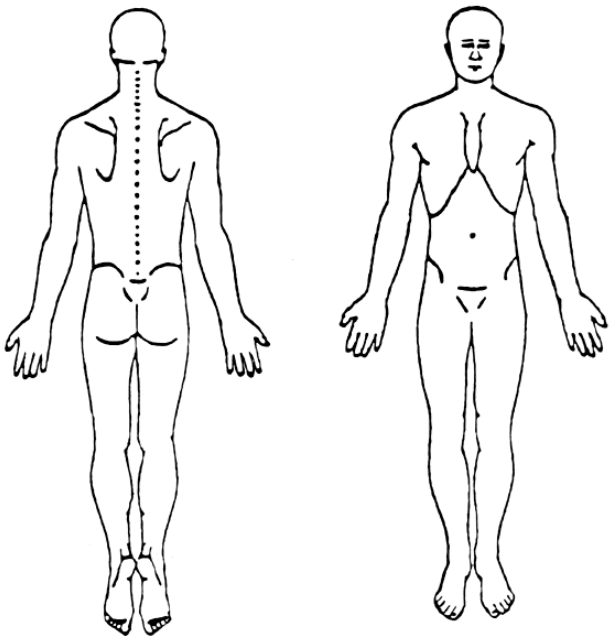
Complaint #4: _____
____ % Of Time Felt? 0-10 Pain Scale _____? Symptoms Without Activity? ___ YES ___ NO
What Activities Make This Symptom Worse? _____
What Makes This Symptom Better? _____

Complaint #5: _____
____ % Of Time Felt? 0-10 Pain Scale _____? Symptoms Without Activity? ___ YES ___ NO
What Activities Make This Symptom Worse? _____
What Makes This Symptom Better? _____

PLEASE USE BACK OF PAGE IF NEEDED

Mark The Areas On Your Body Where You Are Having Symptoms From Your **Work Injury**(ies).

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



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? _____ %

At Work, How Many <u>Hours</u> Per ___ Sit ___ Walk ___ Stand ___ Kneel

Day Do You Do These Activities?

Leave Blank If It Doesn't Apply.

If Done Continuously, Circle.

___ Squat	___ Climb	___ Bend	___ Twist
___ Reach	___ Crawl	___ Push	___ Pull
___ Keyboard	___ Type	___ Mouse	___ Write
___ Finger	___ Grasp		
___ Work Overhead			
___ Flex/Twist/Side-Bend/Extend Your Neck			

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

_____

_____

_____

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

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

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: _____

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? _____

_____

Please List All Of **Your Previous Employers:** (i.e., Before Your Current Work Injury Occurred)

	Employer	Dates Of Employment	Job Title/Duties
A)	_____	_____	_____
B)	_____	_____	_____
C)	_____	_____	_____
D)	_____	_____	_____

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

	Employer	Dates Of Employment	Job Title/Duties
A)	_____	_____	_____
B)	_____	_____	_____
C)	_____	_____	_____
D)	_____	_____	_____

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:

_____

_____

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?

_____

_____

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:

_____

PAST MEDICAL HISTORY:

Please List Information Below With Approximate Dates. **Leave Blank If Denied.**

Childhood Illnesses/Injuries: _____
Allergies: _____ Medications: _____
Surgeries: _____ Adult Illnesses: _____

FAMILY HISTORY:

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

REVIEW OF SYSTEMS:

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

Ears/Nose/Throat: _____ Eyes: _____
Lungs: _____ Liver: _____
Stomach/Intestines: _____ Kidney/Bladder:_____
Reproductive System: _____ Psychological: _____
Neurological: _____ Heart/Circulation: _____

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 Recreational Drugs? ___ YES ___ NO If 'YES', What Kind & How Many Times Per Day Or Week?_____

Injured Worker's Signature: _____ Date: _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE

PHYSICIAN USE ONLY

PHYSICAL EXAMINATION FINDINGS
DIAGNOSTIC TESTING
DIAGNOSIS
DISCUSSION
PERMANENT AND STATIONARY STATUS
CAUSATION - APPORTIONMENT
VOCATIONAL REHABILITATION
IMPAIRMENT RATING (Impairment Report)
FUTURE MEDICAL CARE
COMPLIANCE STATEMENTS
SIGNATURE, COUNTY & DATE