

Please help us to better assist you by completing this questionnaire as fully as possible. Some areas may not be relevant for your situation, but please try to answer as much as possible.

Today's date: \_\_\_\_\_

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age \_\_\_\_\_

Address: \_\_\_\_\_  
street city state zip

Phone: Home: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_

Name of Referring Party: \_\_\_\_\_

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

Occupation or Job Title: \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's address: \_\_\_\_\_  
city state

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ B/P: \_\_\_\_\_

Are you:  Right Handed  Left Handed

Part of Body Injured:

**HISTORY OF THE INJURY & TREATMENT**

Date of Injury: \_\_\_\_\_

Was the onset  Gradual (over a period of time) or  Sudden ?

Describe how the injury occurred. Please be as *specific* as possible:

Did you report the injury?  Yes  No On what day?: \_\_\_\_\_

If yes, to whom?(name & title):

Did you continue working following the injury?  Yes  No

Date of first treatment: \_\_\_\_\_ Where?: \_\_\_\_\_

Who treated you first?: \_\_\_\_\_

What type of treatment?  medications \_\_\_\_\_  
 brace or splint (type) \_\_\_\_\_  
 physical therapy (dates) \_\_\_\_\_  
 chiropractic manipulation(who, how often) \_\_\_\_\_  
\_\_\_\_\_  
 hospitalized (where) \_\_\_\_\_  
 surgery (what kind) \_\_\_\_\_  
(when, by whom) \_\_\_\_\_

other \_\_\_\_\_

Other Doctors you have seen:

List any X-Rays, CT scans, MRIs, Nerve Conduction Studies, blood tests, or any other tests or studies that you have undergone, along with the approximate dates.

**PRESENT COMPLAINTS**

Please describe, in your own words, *exactly* what is bothering you, and how you are affected by your injury:

What are your symptoms associated with/ what brings them on?

What makes your symptoms worse? better?

What can you not do now that you could do before your injury?

**HISTORY OF PREVIOUS INJURY**

Have you have any *previous* problems or injuries with the part of your body that you presently injured?       Yes                       No

If so, when?

What happened?

What were your symptoms **prior** to this injury?

**HISTORY OF SUBSEQUENT INJURY**

**Since** the original injury, have you re-injured the same area?       Yes                       No

If yes, please describe events, and dates:

**WORK HISTORY**

Job Title: \_\_\_\_\_

Employer: \_\_\_\_\_

Date you started working for this employer:

Did you work continuously for your employer until your injury?       Yes                       No

If *No*, describe any breaks in your employment up to your injury:

off work    from: \_\_\_\_\_ to: \_\_\_\_\_                      reason

                  from: \_\_\_\_\_ to: \_\_\_\_\_

                  from: \_\_\_\_\_ to: \_\_\_\_\_

Did you have a physical examination prior to starting work?       Yes

No

Did you have any restrictions?                       Yes                       No

At the time of injury, were you working:  Full time  Part time   
Other

Describe your job's physical activities and requirements

If you use a keyboard, how many hours a day, and how many days a week?

If you lift, what do you lift, and how much does it weigh?

If there is reaching, what do you reach for?

If you kneel, twist, crawl, stoop, or squat, why do you do so?

Have you lost any time from work as a result of your injury?  Yes  No

If so, what are the approximate dates and lengths of time that you missed from work?

Did you return to work since the injury?

Yes  full time  
 part time  
 limited duty (describe restrictions)

No

Are you working *now* for the same employer?

- Yes
  - Regular Duty
  - Part time
  - Limited/Light Duty (specify restrictions)

- No
  - quit
  - was fired
  - laid off for medical reasons
  - laid off for non-medical reasons

Are you working now for a *different* employer? If so, who and type of job

- Yes
  - Regular Duty
  - Limited/Light Duty (specify restrictions)

- No

Name of Doctor (if any), and date, when released to go back to work:

- At the present time, please list your sources of income:
- none
  - present job
  - social security
  - Worker's Comp.
  - Spouse / Relatives
  - retirement pay
  - other

Have you applied for unemployment benefits?  Yes  No

Are you receiving unemployment benefits?  Yes  No

Are you registered with the California Employment Development Department?  Yes  No

**PAST EMPLOYMENT HISTORY**

	<u>Employer</u>	<u>Dates</u>	<u>Job Title</u>
1999			
1998			

1997

1996

1995

Prior to 1995

**PAST MEDICAL HISTORY**

Please list **all** of the following:

Childhood Illnesses & Injuries:

Adult Illnesses:

Adult Injuries:

Have you ever had a job-related injury (before this injury)?  Yes  No

Have you ever been injured in a motor vehicle injury?  Yes  No

Have you ever had any other type of injury?  Yes  No

*Please complete details regarding your previous injuries at the end of this form:*

Surgeries (all):

Family Medical History:

Allergies to Medications:

Medications:

name of drug dose how many times a day for what disease?

Cigarette use: now? how many per day? ever?

Alcohol use: how many drinks per day?

Current physician:

Married?  Yes  No Children?  Yes  No How many?

Hobbies & Off-Work Activities:

walking  housework  grocery shopping  
 gardening  child care  home/auto repair  
 running  aerobics/health club  bowling  
 golf  fishing  tennis  
 hunting  skiing  other sports \_\_\_\_\_

Please answer 'Yes' or 'No' to each of the following:

<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>
<input type="checkbox"/>	<input type="checkbox"/> .....headaches	<input type="checkbox"/>	<input type="checkbox"/> .....vision problems
<input type="checkbox"/>	<input type="checkbox"/> .....ringing in ears	<input type="checkbox"/>	<input type="checkbox"/> .....hearing loss
<input type="checkbox"/>	<input type="checkbox"/> .....sore throat	<input type="checkbox"/>	<input type="checkbox"/> .....chest pain
<input type="checkbox"/>	<input type="checkbox"/> .....shortness of breath	<input type="checkbox"/>	<input type="checkbox"/> .....stomach pain
<input type="checkbox"/>	<input type="checkbox"/> .....burning urination	<input type="checkbox"/>	<input type="checkbox"/> .....coughing up of blood
<input type="checkbox"/>	<input type="checkbox"/> .....blood in bowel movements	<input type="checkbox"/>	<input type="checkbox"/> .....recent weight loss
<input type="checkbox"/>	<input type="checkbox"/> .....morning stiffness	<input type="checkbox"/>	<input type="checkbox"/> .....pains that go from joint
<input type="checkbox"/>	<input type="checkbox"/> .....numbness/tingling in hands or feet		to joint

*Please complete the following questions for each of your prior injuries*

*Injury #1)*

Date of injury \_\_\_\_\_ Part of body injured: \_\_\_\_\_

How did injury occur?

Was the injury Industrial (work-related)?  Yes  No Employer \_\_\_\_\_

Treatment received:

Did you miss time from work?  Yes                      How much? \_\_\_\_\_  
 No

Did you receive disability payments?                       Yes                       No

Any permanent problems as a result of this injury?  Yes                       No

Please describe:

*Injury #2)*

Date of injury \_\_\_\_\_ Part of body injured: \_\_\_\_\_

How did injury occur?

Was the injury Industrial (work-related)?  Yes                      Employer \_\_\_\_\_  
 No

Treatment received:

Did you miss time from work?  Yes                      How much? \_\_\_\_\_  
 No

Did you receive disability payments?                       Yes                       No

Any permanent problems as a result of this injury?  Yes                       No

Please describe:

*Injury #3)*

Date of injury \_\_\_\_\_ Part of body injured: \_\_\_\_\_

How did injury occur?

Was the injury Industrial (work-related)?  Yes                      Employer \_\_\_\_\_  
 No

Treatment received:

Did you miss time from work?  Yes  
 No

How much? \_\_\_\_\_

Did you receive disability payments?  Yes  No

Any permanent problems as a result of this injury?  Yes  No

Please describe: