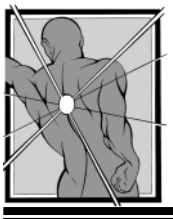

EMERALD COAST CHIROPRACTIC

501-C Highway 98 East
Destin, Florida 32541
850-654-1850

WORKER'S COMPENSATION INJURY QUESTIONNAIRE

Please Print:

Name:_____ Todays Date:_____

Employer's Business Name at time of Accident:_____

Employer's Phone:_____ Employer's Address_____

Occupation:_____

❑Yes ❑No Previous Worker's Compensation Injury? Impairment Rating:_____

Length of time at this job prior to injury:_____

Date of Injury:_____ Time of injury:_____ Last Date Worked:_____

Please explain what you were doing at the time you were injured and how the accident happened (lifting, bending, walking, carrying standing, etc.)_____

_____

When did the pain begin?(please be specific)_____

Where did you first feel it?(please be specific)_____

Was the pain intense at first or did it gradually worsen?_____

REPORT ACCIDENT/ACCIDENT OBSERVER

What date did you report this injury on?_____

Who did you report this injury to?_____Position?_____

Did anyone else observe accident/injury? ❑Yes ❑No If yes, Name:_____

Position:_____

SYMPTOMS FROM ACCIDENT

Did you experience bleeding cuts or bruises? ❑Yes ❑No
If bleeding cuts where?_____ If bruises, where?_____

Please describe how you felt. PLEASE BE SPECIFIC.

Immediately after the accident:_____

Later that ❑Day ❑Night:_____

The next day(s):_____

Check symptoms that have become apparent since the accident/injury:

❑Nervousness	❑Loss of balance	❑Sleeping trouble	❑Headache
❑Neck Pain/Stiffness	❑Loss of smell	❑Toe Numbness	❑Fainting
❑Midback Pain	❑Loss of taste	❑Finger Numbness	❑Anxiety
❑Low Back Pain	❑Loss of memory	❑Cold Hands	❑Seizures
❑Eyes sensitive to light	❑Pins & Needles - Arms	❑Cold Feet	❑Visualdisturbance
❑Pain behind eyes	❑Pins & Needles - Legs	❑Chest Pain	❑Forgetfulness
❑Dizziness	❑Shortness of breath	❑Constipation	❑Blurred Vision
❑Cold sweats	❑Head seems too heavy	❑Diarrhea	❑Double Vision
❑Face flushed	❑Irritability	❑Fatigue	❑Confused
❑Ringing/Buzzing Ears	❑Depression	❑Tension	❑Disoriented
❑Fever	❑Other_____		

MECHANISM OF INJURY:

Please explain the mechanism of the injury *(only fill in those sections that apply to you)*:

FALL:

❑Yes ❑No Did you hit anything when you fell? If yes, what?_____
❑Yes ❑No Were you carrying anything when you fell? If yes, what?_____
How much did it weigh?_____lbs.
❑Yes ❑No Did you twist when you fell? If so, to which side? ❑Left ❑Right
❑Yes ❑No Was the area lighted?

Describe the condition of the area (slippery, graveled, etc.)_____
What part of the body did you fall on?_____
How far did you fall? (In feet) _____
What did you land on?_____

LIFT/PULL:

How much did the object weigh?_____lbs.
❑Yes ❑No Did you fall after the injury? If yes, how far?_____
❑Yes ❑No Did you hit anything when you fell? If yes, what?_____
❑Yes ❑No Were you twisting when you were lifting/pulling? If yes, to which side? ❑Left ❑Right

How far off the ground did you have the object before the pain started?_____
❑Yes ❑No Did you drop the object when the pain started?
❑Yes ❑No Did it land on you? Where?_____
Did you lift with your ❑Legs ❑Back ❑Other_____

BEND:

❑Yes ❑No Were you lifting when you were bent over? If yes, how much did the object weigh?_____lbs.
How far were you bent over?_____
❑Yes ❑No Did you fall when the pain started? How far?_____
❑Yes ❑No Were you twisting when you bent forward? Toward which side? ❑Left ❑Right
❑Yes ❑No Did you land on anything? If so, what?_____

WORK STATUS HISTORY:

❑Yes ❑No Have you lost time from work as a result of this new injury? If yes, please give dates:_____
_____
❑Yes ❑No Have you gone back to work? When:_____
If yes, status or work: ❑Modified ❑Regular
List restrictions you have been placed on:_____
If you have gone back to work, list activities that are:
PAINFUL:_____
DIFFICULT:_____
❑Yes ❑No If you are currently on disability (time loss), do you want to go back to work doing your regular job? If no, why not?_____
❑Yes ❑No Are there any problems you have with a fellow employee, supervisor, or manager that needs to be discussed? If yes, please explain:_____
_____

FIRST DOCTOR/HOSPITAL/CLINIC:

❑Yes ❑No Were you hospitalized as a result of this accident? If yes, where:_____

Doctor 1 Name:_____Date of First Visit:_____

❑Yes ❑No Were you examined? ❑Yes ❑No Were X-rays taken?

What diagnosis did the doctor give you?_____

❑Yes ❑No Were you given treatment? If yes, what type?_____

What benefits did you receive from this treatment?_____
_____
Date of last treatment?_____

❑Yes ❑No Did the doctor refer you to another health professional? If yes, to whom and for what?____
_____

❑Yes ❑No Did you follow the doctor's recommendation? If no, why not?_____
_____

SECOND DOCTOR/CLINIC:

Doctor 2 Name:_____Date of First Visit:_____

❑Yes ❑No Were you examined? ❑Yes ❑No Were X-rays taken?

What diagnosis did the doctor give you?_____

❑Yes ❑No Were you given treatment? If yes, what type?_____
What benefits did you receive from this treatment?_____
_____
Date of last treatment?_____

PRIOR SIMILAR SYMPTOMS:

❑Yes ❑No Did you have any physical complaints just before the accident? If yes, please describe in detail:_____
_____

❑Yes ❑No Have you ever had any prior injuries, accidents, diseases or treatment to the area of your body now affected? If yes, what part was previously injured?_____
_____Date previously injured?_____
Describe previous injury:_____

❑Yes ❑No Were you treated? By whom?_____
Date treatment began:_____Date treatment ended:_____
The last date you felt pain or problems from that previous injury:_____

JOB DESCRIPTION

In terms of an 8 - hour workday: ***Occasionally*** = 33%, ***Frequently*** = 34% to 66%, ***Continuously*** = 67% to 100%

In a typical 8 - hour workday, I (circle the number of hours of activity):

Sit	1	2	3	4	5	6	7	8	Hours
Stand	1	2	3	4	5	6	7	8	Hours
Walk	1	2	3	4	5	6	7	8	Hours

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	❑	❑	❑	❑
Pulling/Pushing	❑	❑	❑	❑

On the job, I lift:	Not at all	Occasionally	Frequently	Continuously
Up to 10 pounds	❑	❑	❑	❑
11 to 24 pounds	❑	❑	❑	❑
25 to 34 pounds	❑	❑	❑	❑
35 to 50 pounds	❑	❑	❑	❑
51 to 74 pounds	❑	❑	❑	❑
75 to 100 pounds	❑	❑	❑	❑

❑Yes ❑No Are you required to bend over while doing any lifting?
❑Yes ❑No Are your feet used in repetitive movements, such as operating foot controls?

Do you use your hands for repetitive actions such as:

	Simple Grasping	Firm Grasping	Find Manipulating
Right Hand	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No
Left Hand	❑Yes ❑No	❑Yes ❑No	❑Yes ❑No

❑Yes ❑No Are you required to work at unprotected heights? If yes, please describe:_____
_____
❑Yes ❑No Are you required to be around moving machinery? If yes, please describe:_____
_____
❑Yes ❑No Are you exposed to marked changes in temperature and humidity? If yes, please describe:_____
❑Yes ❑No Are you required to drive automotive equipment? If yes, please describe:_____
_____
❑Yes ❑No Are you exposed to dust, flames, and/or gases? If yes, please describe:_____
_____
Please list any additional comments:_____
_____
_____
_____
_____
_____

Patient's Signature:_____**Date**:_____