

# Worker's Compensation Injury Questionnaire

## Please Print

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Employer's Business Name at time of Accident: \_\_\_\_\_

Employer's Phone: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Previous Worker's Compensation Injury? \_\_\_\_\_ Yes \_\_\_\_\_ No

Length of time at this job prior to injury: \_\_\_\_\_ Impairment Rating: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time of Injury: \_\_\_\_\_ Last Day Worked: \_\_\_\_\_

Please explain what you were doing at the time of the injury and how the accident happened (lifting, walking, running, carrying, etc) \_\_\_\_\_

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When did the pain begin: (Please be specific) \_\_\_\_\_

When 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: \_\_\_\_\_

Who did you report this injury to? \_\_\_\_\_ Position: \_\_\_\_\_

Did anyone else observe the accident/injury? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, Name: \_\_\_\_\_  
Position: \_\_\_\_\_

## SYMPTOMS FROM ACCIDENT

Did you experience bleeding, cuts or bruises? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes what and where: \_\_\_\_\_

## Please describe how you felt: PLEASE BE SPECIFIC

Immediately after the accident: \_\_\_\_\_

Later that day or night: \_\_\_\_\_

The next day(s): \_\_\_\_\_

## Check symptoms that have been apparent since the accident/injury

<input type="checkbox"/> Nervousness	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Confused
<input type="checkbox"/> Neck Pain/Stiffness	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Tension
<input type="checkbox"/> Ringing/buzzing ears	<input type="checkbox"/> Loss of taste	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Irritability
<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Loss of Memory	<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Fainting
<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> Pins/Needles-Arms	<input type="checkbox"/> Face Flushed	<input type="checkbox"/> Seizures
<input type="checkbox"/> Eyes- light sensitive	<input type="checkbox"/> Pins/Needles-Legs	<input type="checkbox"/> Headache	<input type="checkbox"/> Cold Feet
<input type="checkbox"/> Pain behind eyes	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Constipation
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Sleeping Trouble	<input type="checkbox"/> Cold Hands	<input type="checkbox"/> Depression
<input type="checkbox"/> Head seems heavy	<input type="checkbox"/> Toe Numbness	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Cold Sweats
<input type="checkbox"/> Visual Disturbance	<input type="checkbox"/> Finger Numbness	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever
Other: _____			

(OVER)

**MECHANISM OF INJURY:**

Please explain the mechanism of the injury (only fill in the 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 yes, to which side? \_\_\_ right      \_\_\_ left

\_\_\_ Yes      No \_\_\_ Was the area lighted?

Describe the condition of the area (Wet, Slippery, Graveled, etc): \_\_\_\_\_

What part of your body did you fall on? \_\_\_\_\_

How far did you fall? \_\_\_\_\_

What did you land on? \_\_\_\_\_

**LIFTING/PULLING**

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? \_\_\_ right \_\_\_ left.

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? If yes, where? \_\_\_\_\_

Did you lift with your \_\_\_ Legs      \_\_\_ Back      Other: \_\_\_\_\_

**BENDING**

\_\_\_ Yes      No \_\_\_ Were you lifting when you bent over? If yes, what and how much did it weigh? \_\_\_\_\_

\_\_\_ Yes      No \_\_\_ Did you fall or drop when the pain started? Explain: \_\_\_\_\_

\_\_\_ Yes      No \_\_\_ Were you twisting when you bend forward? To which side      \_\_\_ right      \_\_\_ left.

\_\_\_ Yes      No \_\_\_ Did you land on anything? If yes, what? \_\_\_\_\_

**WORK STATUS HISTORY**

\_\_\_ Yes      No \_\_\_ Have you lost time from work as a result of this new injury? If yes, give dates: \_\_\_\_\_

\_\_\_ Yes      No \_\_\_ Have you gone back to work? When? \_\_\_\_\_

If yes, status of work: \_\_\_ Modified      \_\_\_ Regular Duty

List any restriction that you have been placed on: \_\_\_\_\_

If you have gone back to work, list the activities that are:

PAINFULL \_\_\_\_\_

DIFFICULT \_\_\_\_\_

\_\_\_ Yes      No \_\_\_ If you are currently on disability(placed off work), 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: \_\_\_\_\_