WORK/COMP QUESTIONNAIRE

Name: _____ Date of Accident: _____

1. Name of employer at time of accident: _____
2. Length of time worked there prior to accident: _____
3. Type of work being done at time of injury: _____

   _____
4. In your own words, please describe accident: _____

   _____

   _____

   _____.
5. Have you been treated by another doctor for this accident? Yes No

   If yes, please list doctor's name and address: _____

   _____

   What type of treatment did you receive? _____

   How long were you treated by this doctor? _____
6. Are you: ( ) improved ( ) unchanged ( ) getting worse
7. What types of medicines are you taking? _____

   _____

   Do these medicines help? ( ) Yes ( ) No ( ) Don't know
8. Have you had physical therapy? ( ) Yes ( ) No If yes, how often?

   ( ) Daily ( ) Every other day ( ) Several times a week ( ) Weekly ( ) Every other week

   ( ) Monthly ( ) Other _____

   Does the physical therapy help? ( ) Yes ( ) No ( ) Don't know
9. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?

   ( ) Yes ( ) No ( ) Don't know

   If yes, describe: _____

   _____

   _____

   Were these similar complaints the results of a previous accident(s)? ( ) Yes ( ) No

   Please provide details of accident(s): _____

   _____

   _____
10. Have you had any other serious accidents which required medical care? ( ) Yes ( ) No

    Describe: _____
11. Have you had any serious illnesses that required hospitalization? ( ) Yes ( ) No

    Describe: _____

    _____

    _____

12. Have you had any surgeries? ( ) Yes ( ) No

If yes, list type of surgery and date: _____

_____

_____

13. Have you had any nervous or mental illnesses? ( ) Yes ( ) No

Have you had psychiatric care? ( ) Yes ( ) No

14. Have you received a medical discharge from the Armed Forces? ( ) Yes ( ) No

15. Have you returned to work since this accident? ( ) Yes ( ) No

If you have returned to work since your accident, please fill out the information below:

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY REG. DUTY	FULL-TIME PART-TIME

CURRENT MEDICAL COMPLAINTS

BACK PAIN:

1. Currently, I have pain in my: ( ) low back ( ) mid back ( ) upper back
2. My pain began: ( ) gradually ( ) suddenly
3. I have pain: ( ) sometimes ( ) all of the time
4. My pain goes into my: ( ) right leg ( ) left leg ( ) both
5. I have tingling and/or numbness in my: ( ) right leg ( ) left leg ( ) both
6. My pain is worse when I:
   - cough or sneeze ( ) Yes ( ) No
   - sit ( ) Yes ( ) No
   - bend ( ) Yes ( ) No
   - walk ( ) Yes ( ) No
   - lift ( ) Yes ( ) No
   - push ( ) Yes ( ) No
   - pull ( ) Yes ( ) No
7. My back is worse with sexual activity ( ) Yes ( ) No
8. My pain wakes me up during the night ( ) Yes ( ) No
9. Changes in the weather affect my pain ( ) Yes ( ) No

NECK PAIN:

1. My neck pain began: ( ) gradually ( ) suddenly
2. I have pain: ( ) sometimes ( ) all of the time
3. My pain goes into my: ( ) right arm ( ) left arm ( ) both
4. I have tingling and/or numbness in my: ( ) right arm ( ) left arm ( ) both