

Patient Work Related Accident Questionnaire

1. Patient Name: _____

2. Date the accident occurred or started? ____/____/____

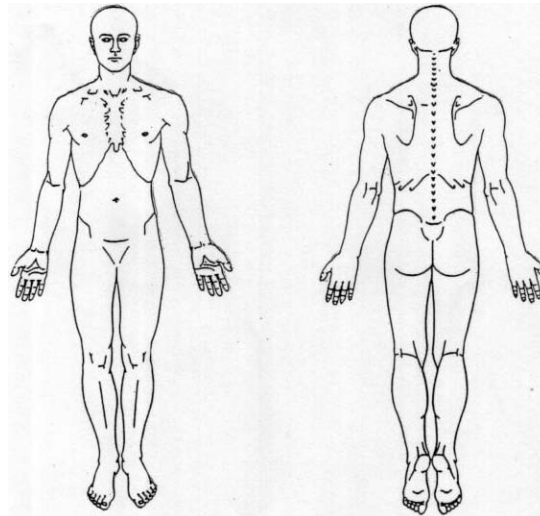
3. Time of day when accident occurred or started? _____

4. Describe how the accident took place

Work Related Accident Questions

- Did the accident occur on the premises of the facility where you normally work (i.e work address)?
- Did the accident occur during your normal working hours?
- Did you report the accident to your employer?
- Is your Employer covered by Workers Compensation Insurance under state law?
- Has your Employer prepared an initial written report?
- Does your Employer's Report describe the condition of symptom you are experiencing?
- Has a claim number been issued for this accident?
- Have you received any written denial of liability from either your Employer or Worker's Insurance Company Payer?





Please mark area(s) of health concern with X.

Addition Information Relating To The Condition

5. Describe your pain: Burning Pain Sharp pain Dull Pain Ache

A. What caused it? _____

B. What aggravates it? _____

C. What relieves it? _____

6. Please check any of the following symptoms you are now experiencing:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Head seems heavy | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Clumsiness |
| <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> tingling in arms/legs | <input type="checkbox"/> Ears Ring |
| <input type="checkbox"/> Hands Cold | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Tingling in legs/feet | <input type="checkbox"/> Face Flushed |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness in hands/arms | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Constipation | <input type="checkbox"/> Numbness legs/feet | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Burning muscle pain | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Irritability | <input type="checkbox"/> Loss of smell |
| <input type="checkbox"/> Chest pain/Rib pain | <input type="checkbox"/> Pain in arms/legs | <input type="checkbox"/> Pain in legs/feet | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Sharp/Shooting pain | <input type="checkbox"/> Loss of strength Legs | <input type="checkbox"/> Loss of strength – arms | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Difficulty swallowing | | <input type="checkbox"/> Other: _____ | |

7. Have you experienced changes to:

- | | | | |
|---------------------------------------|--|---------------------------------------|--|
| <input type="checkbox"/> Eyes (sight) | <input type="checkbox"/> Earring (hearing) | <input type="checkbox"/> Nose (smell) | <input type="checkbox"/> Mouth (taste) |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Bowels | <input type="checkbox"/> Sleep | <input type="checkbox"/> Emotion |
| <input type="checkbox"/> Appetite | | | |

Please explain:



8. Have you missed work or school as a result of your injuries? Yes No

9. Do you smoke? Yes No Number of Packs/Day? _____

10. Do you drink alcohol? Yes No Number of drinks? _____

11. Have you been in our office before? Yes No

12. List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

Previous accident:	Date:
1.	
2.	
3.	

13.

Surgeries/Hospitalizations	Year

14. Allergies?

15. List all medications you are now taking and why:

Name	Quantity/day	Reason

16. Do you now or have you ever:

- Heart Disease
- Stroke
- Thyroid Problem
- Stroke
- Other: _____
- Diabetes
- Tuberculosis
- Kidney Problems
- Seizure Disorder
- Cancer
- Asthma
- Ulcer
- Scoliosis
- High Blood Pressure
- Prostate Disorder
- Cardiovascular problems
- Back Problems

