Healing Hands Wellness Center

Worker's Compensation Injury Questionnaire

Patients Name: ______________________________ **Date of Injury:** ____________________

If your injury involved LIFTING, complete the following section:

From where were you lifting the object? Ground level A surface below ground level
A surface 1 to 3 feet high A surface 3 to 5 feet high A surface above 5 feet high

How many pounds was the object you were lifting? 1 to 5 pounds 5 to 10 pounds
10 to 20 pounds 20 to 40 pounds 40 to 60 pounds Over 60 pounds

What position were you in while lifting the object? Back was upright and straight
Bent over at the waist Twisted to the left side Twisted to the right side

What type of pain did you feel immediately after the injury? Gripping pain Sharp pain
Dull pain Aches Popping feeling Paralysis

If your injury involved FALLING, complete this section:

From where did you fall at work? Onto the ground while walking Onto the ground while running
From 1 to 3 feet high From 3 to 5 feet high From 3 to 5 feet high
From 5 to 8 feet high From higher than 8 feet

What part of your body did you land on? Head Neck Right Shoulder
Left Shoulder Right Arm Left Arm Right Hand Left Hand
Back Right Buttock Left Buttock Tail Bone Right Hip
Left Hip Right Leg Left Leg Right Knee Left Knee
Right Foot Left Foot

What other areas were injured as a result of your fall? Head Neck Right Shoulder
Left Shoulder Right Arm Left Arm Right Hand Left Hand
Back Right Buttock Left Buttock Tail Bone Right Hip
Left Hip Right Leg Left Leg Right Knee Left Knee
Right Foot Left Foot

Other work related injuries, not caused by lifting or a fall: Raised up from bending over Twisted at the waist
Wrist injury from repetitive use Wrist injury from pulling

Please describe ALL injuries in your own words: ____

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Job Analysis Information:

What regular activities do you perform at your job? Sitting Standing Walking
Running Driving Lifting Bending Squatting Crawling
Climbing Crouching Kneeling Pushing/Pulling
Maintain awkward position Reaching above shoulders

How much do you regularly lift at your job? Little to none 1 to 10 pounds
10 to 20 pounds 20 to 40 pounds 40 to 60 pounds 60 to 80 pounds
80 to 100 pounds Over 100 pounds

Do you regularly bend over while lifting? Yes No

Are your hands subject to any of the listed below repetitive movements?
Light grasping (left hand) Light grasping (right hand) Light grasping both hands
Firm grasping (left hand) Firm grasping (right hand) Firm grasping both hands
Typing Using a computer mouse or trackball

How many hours are you required to regularly perform each of the following activities at your job?

Sitting:	1-2 hours	2-4 hours	4-6 hours	6-8 hours
Standing:	1-2 hours	2-4 hours	4-6 hours	6-8 hours
Walking:	1-2 hours	2-4 hours	4-6 hours	6-8 hours
Lifting:	1-2 hours	2-4 hours	4-6 hours	6-8 hours

Check below if yes:

Did you report this injury in writing to at work?
Have you seen another health care provider since the accident?

Describe any symptoms

During the accident: ______________________________

Immediately after the accident: ______________________________

Later that day: ______________________________

Next day or later: ______________________________

What are your present complaints and symptoms:

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Since this injury occurred are your symptoms
Improving Getting worse Same

Please check symptoms you have noticed since the accident:

Headache	Irritability	Numbness in toes	Face flushed	Vomiting
Neck pain	Chest pain	Difficulty breathing	Buzzing in ears	Nausea
Neck stiffness	Dizziness	Fatigue	Loss of balance	Stomach upset
Sleeping problems	Depression	Head seems heavy	Fainting	Constipation
Back pain	Tension	Memory loss	Fever	Diarrhea
Vision problems	Cold feet	Loss of taste	Cold sweats	Nervousness
Ringing in ears	Cold Hands	Loss of smell	Difficulty swallowing	Pins & needles in arms

Were you on any medications at the time of the accident? Yes No

If so, what medications? ______________________________

Did you take any medications after the accident? Yes No

If so, what medications? ______________________________

Have you lost any time from work as a result of this accident? Yes No If yes, please complete the following:

Last day worked: ______________________________

Have you noticed any activity restrictions as a result of this injury? Yes No

If yes, please describe in detail: ______________________________

Other pertinent information: ______________________________

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Upper and Lower Back:

Do you have upper back pain? Yes No If yes, is there scapular pain? Yes No If yes, Right Left

Do you have lower back pain? Yes No If yes, is there stiffness? Yes No

What is the pain aggravated by? ______________________________

Do you have any restriction of motion? Yes No

Due to the back pain, do you experience any of the following? If yes, please describe the pain.:

Radiating pain: ______________________________

Hip pain, right or left: ______________________________

Thigh pain, right or left: ______________________________

Knee pain, right or left: ______________________________

Ankle or foot pain, right or left: ______________________________

Upper Extremities: Check all that apply

Shoulder	Right Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9
Arm	Right Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9
Elbow	Right Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9
Forearm	Right Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9
Wrist	Right Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9
Hand	Right Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9
Fingers	Right Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9
Chest pain	Right Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9

Lower Extremities: Check all that apply

Hip	Right Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9
Thigh	Right Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9
Knee	Right Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9
Ankle	Right Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9
Foot	Right Left	Stiffness	Swelling	Restricted Motion	Is the pain Constant or Intermittent	Check the level of severity: 0 1 2 3 4 5 6 7 8 9

Patient Signature ______________________ **Date** ______________