Work -Related Injury Questionnaire

Employer at time of injury ________________________________Phone __________________
Address ___________________City ________________State ____________Zip ___________

Job Title ______________________Length of time working prior to accident _______________
Type of work being performed at time of injury____

Describe injury / accident
____

Before accident have you experienced similar/same symptoms? Yes____ No____ If yes, describe____

List and describe any additional injuries/accidents____

____
If you have returned to work since your accident, please complete the information below:

DATE	EMPLOYER	OCCUPATION	Light Duty Regular Duty	Full-time Part Time

JOB DESCRIPTION
"On the job I lift/carry" None Infrequent Occasional Intermittent Constant

	1x /hr	up to 15x /hr	up to 60x /hr	60+ /hr
up to 10 lbs	☐	☐	☐	☐
11-25	☐	☐	☐	☐
26-50	☐	☐	☐	☐
1 -75	☐	☐	☐	☐
76-100	☐	☐	☐	☐
100+	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Crouching	☐	☐	☐	☐
Climbing	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Pushing	☐	☐	☐	☐
Pulling	☐	☐	☐	☐
Reaching	☐	☐	☐	☐
Above Shoulder level	☐	☐	☐	☐
At Shoulder level	☐	☐	☐	☐
Below Shoulder level	☐	☐	☐	☐

In a typical 8-hour workday how many hours do you sit _______ stand _______ walk ________?

On the job do you perform repetitive lifting? ☐ Yes ☐ No Bending? ☐ Yes ☐ No
Do your hands perform repetitive actions such as ☐ Simple Grasping ☐ Firm Grasping ☐ Fine Manipulating?

Are your feet used for repetitive movements, such as operating foot controls? ☐ Yes ☐ No

Patient Signature____ **Date**____________________