

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”
 Constant

	None	Infrequent	Occasional	Intermittent	
	<i>1x /hr</i>	<i>up to 15x /hr</i>	<i>up to 60x /hr</i>		<i>60+</i>
<i>/hr</i>					
up to 10 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-25	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26-50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1 -75	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
76-100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
100+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Above Shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At Shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Below Shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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** _____