



**Black Hills Orthopedic
& Spine Center, P.C**

WORKER'S COMPENSATION QUESTIONNAIRE

About the Worker's Compensation Questionnaire:

As the patient, you should be aware that South Dakota State Law requires that all medical records relating to your claim be made available to the employer and to the worker's compensation insurance company.

This information is NOT CONFIDENTIAL. We do respect your privacy and we realize that you may consider some information to be private and personal.

This questionnaire provides the background information that is necessary to manage a worker's compensation claim. We ask that you complete this information so that we can give you the highest possible quality of care.

Bryan D. Den Hartog, M.D.

Worker's Compensation History

Lower Extremity Evaluation

1. Name: _____ 2. Today's Date: _____/_____/_____
Month Day Year

3. Your age: _____ years

4. Hand dominance: _____ right _____ left _____ ambidextrous

5. Height: _____ feet _____ inches 6. Weight: _____ pounds

7. Type of problem (check all that apply)

- | | |
|-------------------------|------------------------|
| RIGHT: _____ Hip | LEFT: _____ Hip |
| _____ Thigh | _____ Thigh |
| _____ Knee | _____ Knee |
| _____ Calf | _____ Calf |
| _____ Ankle | _____ Ankle |
| _____ Foot | _____ Foot |
| _____ Toe | _____ Toe |

8. When did your symptoms begin? _____

9. Was there a specific injury? _____ Yes _____ No If so, when? _____

Describe the injury: _____

10. Did you report the problem at work? _____ Yes _____ No

11. Have you seen a doctor for this problem? _____ Yes _____ No

If yes, which doctor(s)? _____

12. Have you had any of the following tests?

- | | |
|-----------------|----------------------------------|
| _____ X-rays | _____ EMG-Nerve Conduction Study |
| _____ CT scan | _____ MRI |
| _____ Bone scan | |

13. Have you taken medications for *this* problem? _____ Yes _____ No

If so, are you still taking medications for this problem? _____ Yes _____ No

If you remember, please list the name(s) of the medication(s):

Drug Name	How long did you take it?	Was it helpful?	Any side effects or problems?

14. Have you used any of the following *for the current problem*?

Ankle brace Cast Foot pads
 Knee pad/brace Shoe insert Other splint or brace

15. Have you had a cortisone shot *for this problem*? Yes No

If so, was it helpful? Yes No

Were there any problems after the injections? Yes No

16. Have you been to physical therapy *for the current problem*? Yes No

Facility: _____ # of sessions: _____ or # of weeks: _____

Modalities: Exercises Ultrasound Electrical Stimulation Iontophoresis

Whirlpool Massage Hot Packs Ice

17. Have you ever had a previous injury or problem involving this area of your body? Yes No

If so, please describe: _____

Occupational History

18. Current employer: _____ City: _____

19. When did you start working for this employer? _____

20. Is the employer named above the employer responsible for your claim? Yes No

If not, who is the responsible employer? _____

21. Are you working now? Yes No If not, how long have you been off work? Since ____/____/____

If you are working, are you working _____ *full time* or _____ *part time*?

If you are working, how many hours _____ *daily* or _____ *weekly*?

If you are working, are you working _____ *full duty at your regular job* or _____ *restricted duty or a different job*?

List specific restrictions *if applicable*:

Lifting restrictions _____ pounds

No use in _____ hand

No repetitive bending, kneeling, squatting, stair climbing

Wear splint, brace, pad or strap

Limited standing, walking

Take extra breaks

List any other restrictions _____

Which doctor issued these work restrictions? _____

22. Please tell us about the job that you were doing when the problem started (original or normal job for the responsible employer):

Job title: _____ Department: _____

How long have you done (or did you do) this job? _____

Describe the job – what do you do? _____

23. Does this job require (check all that apply):

_____ Heavy lifting (over 50 lbs) _____ Frequently _____ Occasionally

_____ Moderate lifting (15-50 lbs) _____ Frequently _____ Occasionally

_____ Light lifting (under 15 lbs) _____ Frequently _____ Occasionally

_____ Repeated or sustained walking on uneven ground

_____ Repeated or sustained standing or walking on incline (i.e. roof)

_____ Repeated or sustained knee bending or squatting

_____ Repeated or sustained walking or standing on hard surfaces (i.e. concrete)

24. Do you think that your problems have been caused or significantly aggravated by this job? _____ Yes _____ No

If so, is it _____ because of a sudden, specific injury?

Or _____ because of work-related overuse?

If you think the problem is due to work-related overuse, can you identify any particular aspect of this job which you think may have caused your problem(s)? How did this job cause overuse?

25. Please list all of your previous employers:

Employer	City	Date Hired	Date Employment Ended	Job Title

Do you do any other kind of work now? This may include paid housekeeping, at-home day care, part-time labor, occasional odd jobs, anything else for which you are paid?

_____ Yes _____ No

If yes, have you had to give this other work up recently?

_____ Yes _____ No

General Medical History

26. Please list **ALL** current medications (including any listed earlier in the questionnaire)

Are you taking oral contraceptives or female hormones? Yes No (required)

Drug Name	Drug Frequency	Used to Treat which problem

27. Are you allergic to any medications? Yes No

Which medications are you unable to take, and why?

Drug Name	What happens when you take it?

28. Do you have a history of (check all that apply)

- Stomach troubles or ulcers
- (females) delivery of a baby within the last 2 year or currently pregnant
- Diabetes Mellitus
- Thyroid or other hormone problems
- High blood pressure
- Heart problems Heart murmur History or heart attack Irregular heart beat
- Asthma or breathing problems
- Arthritis

29. Do you smoke, or did you smoke? Yes No

If you smoke, how many packs per day do you smoke? _____

If you quit smoking, how long ago did you quit? _____ (congratulations!)

Family History

30. Is there someone in your family that has *(check all that apply)*

- Diabetes Mellitus
- Thyroid problems
- Arthritis
- Carpal Tunnel Syndrome

Social History

We need to know enough about your personal life to determine whether your current problems are work-related. We do ask that you provide this information.

31. Exercise and Sports (in addition to work): *Please check activity and frequency.*

- | | | |
|--|---|--|
| <input type="checkbox"/> walking at least two miles | <input type="checkbox"/> 2 or more times weekly | <input type="checkbox"/> at least weekly |
| <input type="checkbox"/> running, rowing, or bicycling vigorously | <input type="checkbox"/> 2 or more times weekly | <input type="checkbox"/> at least weekly |
| <input type="checkbox"/> weight lifting, stair climbing, etc (gym) | <input type="checkbox"/> 2 or more times weekly | <input type="checkbox"/> at least weekly |
| <input type="checkbox"/> lap swimming | <input type="checkbox"/> 2 or more times weekly | <input type="checkbox"/> at least weekly |
| <input type="checkbox"/> softball, basketball, hockey, or tennis | <input type="checkbox"/> 2 or more times weekly | <input type="checkbox"/> at least weekly |
| <input type="checkbox"/> golf (walking) | <input type="checkbox"/> 2 or more times weekly | <input type="checkbox"/> at least weekly |
| <input type="checkbox"/> golf (riding) or bowling | <input type="checkbox"/> 2 or more times weekly | <input type="checkbox"/> at least weekly |
| <input type="checkbox"/> other sport _____ | <input type="checkbox"/> 2 or more times weekly | <input type="checkbox"/> at least weekly |

Have you had to give up any of these activities recently? Yes No

32. Please circle the highest grade or year of school you attended

- | | | | |
|-----------------|-------------|-----|--------------|
| 1 2 3 4 5 6 7 8 | 9 10 11 12 | GED | 1 2 3 4 5 6+ |
| Elementary | High School | | College |

Thank you for your help!!

If you would like us to send a copy of today's records to your doctor, please indicate:

Physician Name: _____

Address (if known) _____
