Workers' Compensation Questionnaire

About the Workers' 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 workers' 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 workers' compensation claim. We ask that you complete this information so that we can give you the highest possible quality of care.

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Workers' Compensation History

1. Name: _____ **2. Today's Date:** _____

3. Age: _____ **4. Hand Dominance:** ◇ Right ◇ Left ◇ Ambidextrous

5. Height: _____ **6. Weight:** _____

7. Type of Problem (check all that apply)**:**

LEFT
- ◇ Hip
- ◇ Thigh
- ◇ Knee
- ◇ Calf
- ◇ Ankle
- ◇ Foot
- ◇ Toe

RIGHT
- ◇ Hip
- ◇ Thigh
- ◇ Knee
- ◇ Calf
- ◇ Ankle
- ◇ Foot
- ◇ 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

12. Have you had any of the following tests?

◇ X-Rays ◇ CT Scan ◇ EMG-Nerve Conduction Study
◇ MRI ◇ Bone Scan

13. Have you taken medication(s) 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?	Side effects/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? _____

If you are working, are you working: ◇ Full time ◇ 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

◇ Other restriction(s): _____

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 your problems were 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:	Last Day:	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, or anything else for which you are paid. ◇ Yes ◇ No

If yes, have you had to give up this other work recently? ◇ Yes ◇ No

General Medical History

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

Drug name:	Dosage frequency:	Used to treat which problem:

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

27. Are you allergic to any medications? ◇ Yes ◇ No If so, please list below

Drug name:	What happens when you take it?

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

- ◇ Stomach troubles or ulcers
- ◇ Delivery of a baby within the last 2 years/currently pregnant
- ◇ Diabetes Mellitus
- ◇ Thyroid or other hormone problems
- ◇ High blood pressure
- ◇ Heart problems
- ◇ Heart murmur
- ◇ History or heart attack
- ◇ Irregular heartbeat
- ◇ Asthma or breathing problems
- ◇ Arthritis

29. Do you smoke, or did you once 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*

◇ Walking at least two miles	◇ Two or more times weekly	◇ At least weekly
◇ Running, rowing, or bicycling vigorously	◇ Two or more times weekly	◇ At least weekly
◇ Weight lifting, stair climbing, etc. (gym)	◇ Two or more times weekly	◇ At least weekly
◇ Lap swimming	◇ Two or more times weekly	◇ At least weekly
◇ Softball, basketball, hockey and/or tennis	◇ Two or more times weekly	◇ At least weekly
◇ Golf (walking)	◇ Two or more times weekly	◇ At least weekly
◇ Golf (riding) or bowling	◇ Two or more times weekly	◇ At least weekly
◇ Other sport _____	◇ Two or more times weekly	◇ At least weekly

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

Elementary: 1 2 3 4 5 6 7 8 High school: 9 10 11 12 GED College: 1 2 3 4 5 6+

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): _____

_____