

## INJURED WORKER QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Current employer: \_\_\_\_\_ SSN: \_\_\_\_\_

Job Title: \_\_\_\_\_

### INJURY / ONSET OF INJURY

1. What is the reason you are here today?
  
2. When did your problem(s) start? \_\_\_\_/\_\_\_\_/\_\_\_\_ When did you report it? \_\_\_\_/\_\_\_\_/\_\_\_\_
  
3. What employer were you working for when your problem(s) started? \_\_\_\_\_
  
4. Describe, in detail, how your problem(s) occurred:
  
  
  
  
  
  
  
  
  
  
5. Do you have a prior injury or problem similar to or that was made worse by this injury or exposure?  
 Yes  No If yes, briefly describe:
  
  
  
  
  
  
  
  
  
  
6. Describe what you are experiencing – what do you feel where, what makes it better or worse:
  
  
  
  
  
  
  
  
  
  
7. What have you tried so far to help with this problem?
  
  
  
  
  
  
  
  
  
  
8. What is your work status now?  
 Full duty  Modified duty  Off Work  Not employed  Retired

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, please draw in your face.

- Aching = x x x**
- Numbness = 0 0 0**
- Pins & needles = ( ( (**
- Burning = = = =**
- Stabbing = / / /**
- Other = . . . .**

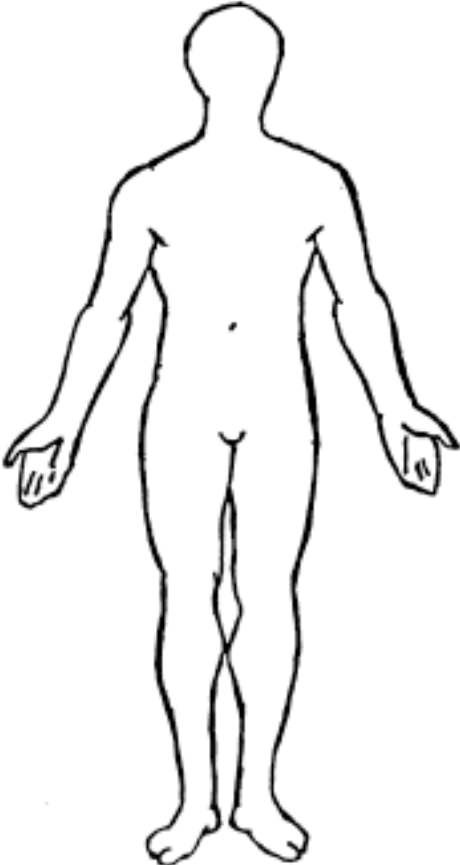
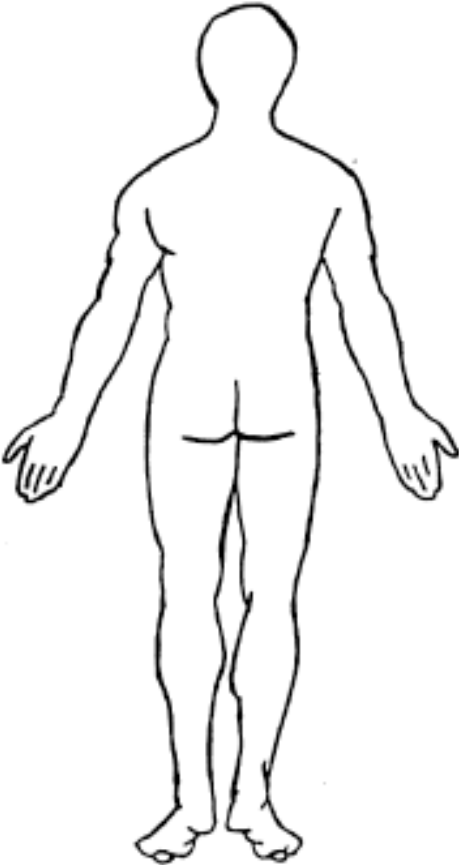
**BACK SIDE**

**FRONT SIDE**

LEFT SIDE

RIGHT SIDE

LEFT SIDE



Signature: \_\_\_\_\_

Date: \_\_\_\_\_