

**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 1X P/HR	OCCASIONAL UP TO 15X P/HR	INTERMITTENT UP TO 60X P/HR	CONSTANT 60+ P/HR
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"/>
51 -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					
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 \_\_\_\_\_