

WORKERS' COMPENSATION PATIENT QUESTIONNAIRE

Dear Patient/Injured Worker:

It is important in a workers' compensation case to establish a complete and accurate base of personal and historical information. This information often becomes a critical part of the decision making process in coming to final determinations or conclusions about your case. Therefore, **your help and cooperation in answering this questionnaire as completely and accurately as possible is necessary and appreciated.** This is very important to the people involved in handling your case and for you to receive appropriate and fair compensation.

PLEASE, REVIEW AND COMPLETE THIS PATIENT QUESTIONNAIRE. DOING THIS, WILL SIGNIFICANTLY REDUCE YOUR TIME IN THE OFFICE. THE AMOUNT OF TIME, WHICH HAS BEEN SCHEDULED FOR YOUR APPOINTMENT, DOES TAKE INTO CONSIDERATION THAT THIS HAS BEEN DONE. THANK YOU VERY MUCH!

PHYSICIAN USE ONLY:

Evaluation Date: _____
Evaluation Began: _____ A.M. _____ P.M. _____
Evaluation Ended: _____ A.M. _____ P.M. _____

Employee Information

Name: _____ Age: _____ Date: _____

Address: (complete mailing address) _____

Phone No.: (____) _____ Date Of Birth: _____ Soc. Sec. No.: _____

__ Male __ Female * __ Right Handed __ Left Handed __ Both * Height: _____ Weight: _____

Employer Information: (Your Employer At The Time You Were Injured)

Name Of Business: _____ Phone No.: (____) _____

Address: _____

Workers' Compensation Insurance Carrier Information:

Name: _____ Phone No.: (____) _____

Address: _____

Claims Representative: _____ Fax No.: (____) _____

Claim No.: _____

Information About Your Work Injury:

Date Of Injury: _____ Time The Injury Occurred: _____ A.M. _____ P.M.

Date You Reported Your Injury To Your Employer/Supervisor: _____

Name Of Person You Reported Your Injury To: _____

Where Did Your Injury Occur? (Address Or Description Of Location): _____

Attorney Information: () Check If None

Name: _____ Phone No.: (____) _____

Address: _____

HISTORY OF THE INJURY:

Please Describe How Your Work Injury Occurred: _____

Please List The Injured Body Parts, As A Result Of Your Work Injury:

(History Of The Injury - continued)

How Did Your Symptoms Come On? ___ Suddenly ___ Gradually **If 'Gradually',** Over What Period of Time? _____

When Did Your Realize/Know That You Were Injured? Explain: _____

HISTORY OF TREATMENT:

When Did You First Seek Treatment For Your Injury? Date: _____

Did Your Employer Send You For Treatment? ___ YES ___ NO

Did You Seek Treatment On Your Own? ___ YES ___ NO

'INITIALLY', Did You Go To A Hospital/Emergency Room? ___ YES ___ NO **If 'YES',**

Answer The Questions Below. **If 'NO',** Go To The *Name Of Doctor/Facility #1* On This Page.

Name Of Hospital/ER? _____ City: _____

Were You Admitted To The Hospital? ___ YES ___ NO If 'YES', How Long? _____

Name Of Doctor(s) At The Hospital/ER Who Treated You? _____

Describe The Type Of Treatment &/Or Diagnostic Testing That Was Done: _____

What Did The Hospital Doctor(s) Say Was Wrong With You? _____

Were You Told That You Would Need More Treatment? ___ YES ___ NO If 'YES', Explain: _____

Did The Doctor(s) Restrict Or Modify Your Work Activities? ___ YES ___ NO If 'YES', How? _____

Please list **ALL** Doctors You Have Seen Regarding Your Work Injury. Please List Them In Chronological Order/**The Order You Saw Them In:**

Name Of Doctor/Facility #1: _____ **City/Location:** _____

Type Of Doctor (degree or specialty): _____

Describe Treatment And/Or Tests: _____

What Did This Doctor Say Was Wrong With You? _____

Date When Treatment Started: _____ Date When Treatment Stopped: _____

How Many Treatments/Visits Were There? _____ How Long Were The Treatments? _____

What Was The Result/Outcome Of The Treatment? _____

Still Treating With This Doctor? ___ YES ___ NO If 'YES', How Often? _____

Did This Doctor Take You Off Work? ___ YES ___ NO If 'YES', Give Dates: _____

(Dr. #1 – continued)

Did This Doctor Restrict Or Modify Your Work Activities? ___ YES ___ NO If 'YES', How?

Did This Doctor Say You Would Need More Treatment? ___ YES ___ NO If 'YES', Explain:

Did This Doctor Refer You Anywhere Else? ___ YES ___ NO If 'YES', Where And Why?

Name Of Doctor/Facility #2: _____ City/Location: _____

Type Of Doctor (degree or specialty): _____

Describe Treatment And/Or Tests: _____

What Did This Doctor Say Was Wrong With You? _____

Date When Treatment Started: _____ Date When Treatment Stopped: _____

How Many Treatments/Visits Were There? _____ How Long Were The Treatments? _____

What Was The Result/Outcome Of The Treatment? _____

Still Treating With This Doctor? ___ YES ___ NO If 'YES', How Often? _____

Did This Doctor Take You Off Work? ___ YES ___ NO If 'YES', Give Dates: _____

Did This Doctor Restrict Or Modify Your Work Activities? ___ YES ___ NO If 'YES', How?

Did This Doctor Say You Would Need More Treatment? ___ YES ___ NO If 'YES', Explain:

Did This Doctor Refer You Anywhere Else? ___ YES ___ NO If 'YES', Where And Why?

Name Of Doctor/Facility #3: _____ City/Location: _____

Type Of Doctor (degree or specialty): _____

Describe Treatment And/Or Tests: _____

What Did This Doctor Say Was Wrong With You? _____

Date When Treatment Started: _____ Date When Treatment Stopped: _____

How Many Treatments/Visits Were There? _____ How Long Were The Treatments? _____

What Was The Result/Outcome Of The Treatment? _____

Still Treating With This Doctor? ___ YES ___ NO If 'YES', How Often? _____

Did This Doctor Take You Off Work? ___ YES ___ NO If 'YES', Give Dates: _____

Did This Doctor Restrict Or Modify Your Work Activities? ___ YES ___ NO If 'YES', How?

Did This Doctor Say You Would Need More Treatment? ___ YES ___ NO If 'YES', Explain:

Did This Doctor Refer You Anywhere Else? ___ YES ___ NO If 'YES', Where And Why?

(History Of Treatment – continued)

Name Of Doctor/Facility #4: _____ City/Location: _____

Type Of Doctor (degree or specialty): _____

Describe Treatment And/Or Tests: _____

What Did This Doctor Say Was Wrong With You? _____

Date When Treatment Started: _____ Date When Treatment Stopped: _____

How Many Treatments/Visits Were There? _____ How Long Were The Treatments? _____

What Was The Result/Outcome Of The Treatment? _____

Still Treating With This Doctor? ___ YES ___ NO If 'YES', How Often? _____

Did This Doctor Take You Off Work? ___ YES ___ NO If 'YES', Give Dates: _____

Did This Doctor Restrict Or Modify Your Work Activities? ___ YES ___ NO If 'YES', How? _____

Did This Doctor Say You Would Need More Treatment? ___ YES ___ NO If 'YES', Explain: _____

Did This Doctor Refer You Anywhere Else? ___ YES ___ NO If 'YES', Where And Why? _____

Name Of Doctor/Facility #5: _____ City/Location: _____

Type Of Doctor (degree or specialty): _____

Describe Treatment And/Or Tests: _____

What Did This Doctor Say Was Wrong With You? _____

Date When Treatment Started: _____ Date When Treatment Stopped: _____

How Many Treatments/Visits Were There? _____ How Long Were The Treatments? _____

What Was The Result/Outcome Of The Treatment? _____

Still Treating With This Doctor? ___ YES ___ NO If 'YES', How Often? _____

Did This Doctor Take You Off Work? ___ YES ___ NO If 'YES', Give Dates: _____

Did This Doctor Restrict Or Modify Your Work Activities? ___ YES ___ NO If 'YES', How? _____

Did This Doctor Say You Would Need More Treatment? ___ YES ___ NO If 'YES', Explain: _____

Did This Doctor Refer You Anywhere Else? ___ YES ___ NO If 'YES', Where And Why? _____

Were Any Other Tests, Examinations, Treatments, or Therapy Done That Were Not Described Above? ___ YES ___ NO If 'YES', Please Describe What Was Done And What The Result Was: (use the back of this page if necessary): _____

(History Of Treatment – continued)

Do You Treat Yourself? ___ YES ___ NO If 'YES', Please Explain How: _____

Are You Currently Taking Medication To Relieve The Effects Of This Injury? ___ YES ___ NO
If 'YES', Please Describe What You Take, (Prescription or Non-Prescription), How Much It Helps,
How Often You Take It, Etc.: _____

Are You Currently Using A Brace, Support, Cane, Crutch(es), Wheelchair, TENS Unit, Or Other
Aid Because Of The Effects Of This Injury? ___ YES ___ NO If 'YES', Please Describe Type
And How Often It Is Used: _____

What Treatment(s) Offer You The Most Relief, And How Long Do The Benefits Last?

Have There Been Any Recommendations For Diagnostic Testing Or Treatment That You Have Not
Received? If 'YES', What Was Recommended, And Who Recommended It?

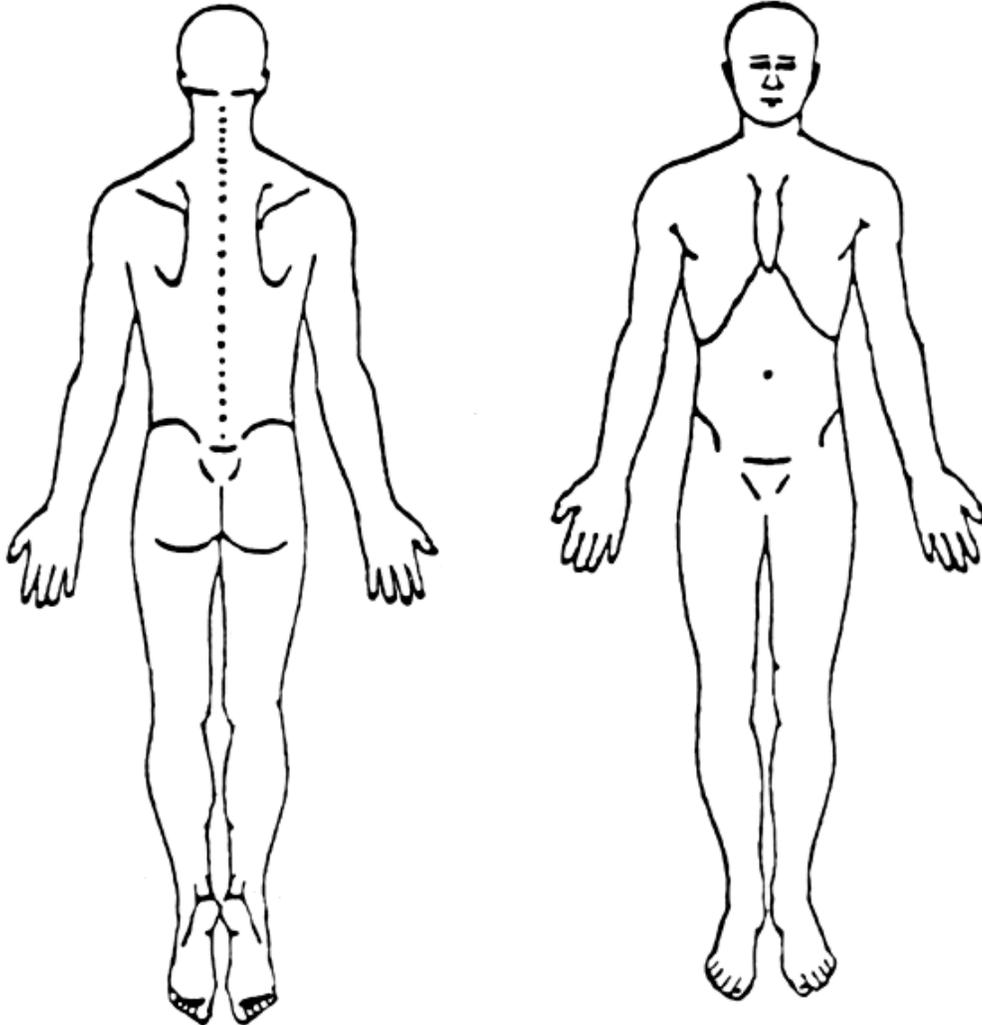
HISTORY OF OTHER INJURIES:

Have You Ever Experienced The Same Or Similar Symptoms/Problems **BEFORE** This Work Injury?
___ YES ___ NO If 'YES', Please Explain In Detail:

CURRENT SYMPTOMS:

Mark The Areas On Your Body Where You Are Having Symptoms From Your **Work Injury**(ies). Also, Review The Pain Scale On The Bottom Of This Page. The Doctor Will Be Asking You Questions.

P = Pain **N** = Numbness/Tingling **T** = Tenderness **B** = Burning **R** = Radiating



PAIN SCALE

0-1	=	Minimal	=	The pain is an annoyance but does not stop me from working.
2-3	=	Slight	=	I can tolerate the pain but it causes some difficulty in doing my work. However, it does not stop me from working.
5	=	Moderate	=	The pain causes a marked handicap in my ability to work, but I can continue.
7-8	=	Moderate To Severe	=	The pain is approaching the worst I have ever experienced or could imagine. It causes a significant problem with working and most of the time I can't.
10	=	Severe	=	The pain is the worst I have ever experienced or could imagine and causes me to stop all work and activity.

Please list your current symptoms/complaints resulting FROM YOUR WORK INJURY:

Complaint #1: _____

What Percentage Of The Time Do You Experience/Feel This Symptom? _____%

What Activities Make This Symptom Worse? _____

What Makes This Symptom Better? _____

Can/Do You Have This Symptom Without Activity? _____

Pain Scale _____ 0 - 10. The Doctor Will Discuss This With You.

Complaint #2: _____

What Percentage Of The Time Do You Experience/Feel This Symptom? _____%

What Activities Make This Symptom Worse? _____

What Makes This Symptom Better? _____

Can/Do You Have This Symptom Without Activity? _____

Pain Scale _____ 0 - 10. The Doctor Will Discuss This With You.

Complaint #3: _____

What Percentage Of The Time Do You Experience/Feel This Symptom? _____%

What Activities Make This Symptom Worse? _____

What Makes This Symptom Better? _____

Can/Do You Have This Symptom Without Activity? _____

Pain Scale _____ 0 - 10. The Doctor Will Discuss This With You.

Complaint #4: _____

What Percentage Of The Time Do You Experience/Feel This Symptom? _____%

What Activities Make This Symptom Worse? _____

What Makes This Symptom Better? _____

Can/Do You Have This Symptom Without Activity? _____

Pain Scale _____ 0 - 10. The Doctor Will Discuss This With You.

Complaint #5: _____

What Percentage Of The Time Do You Experience/Feel This Symptom? _____%

What Activities Make This Symptom Worse? _____

What Makes This Symptom Better? _____

Can/Do You Have This Symptom Without Activity? _____

Pain Scale _____ 0 - 10. The Doctor Will Discuss This With You.

(Current Symptoms - continued)

Is There A Time Of Day That You Feel Worse? ___ YES ___ NO If 'YES', Please Explain:

In The Last **Two Months** Has Your Condition? ___ Stayed The Same ___ Improved ___ Worsened
___ Fluctuated But Overall Has Stayed About The Same

If Your Condition Has **Worsened**, Please Explain: _____

If Your Condition **Continues To Improve**, Please Explain: _____

Do You Feel That Your Condition Will Improve With Time? ___ YES ___ NO Please Explain:

Before This Work Injury, How Would You Describe Your Health? ___ Excellent ___ Good ___ Fair
Or ___ Poor If 'Fair' Or 'Poor', Please Explain: _____

JOB DESCRIPTION:

What Is Your Job Title? (**AT THE TIME OF YOUR INJURY**): _____

Describe The Nature Of Your Work: _____

When Did You Start Working For This Employer? _____

How Many Hours Per Day Do You Normally Work? _____

What Hours Do You Normally Work? _____

How Many Days Per Week Do You Work? _____ How Many Days In A Row? _____

How Long Is Your Lunch Break? _____ How Long Are Your Rest Breaks? _____

How Many Rest Breaks Do You Get In A Normal Work Shift? _____

What Percent Of Your Work Day Do You Work Indoors? _____ % Outdoors? _____ %

At Work, How Many Hours Per Day Do You Do These Activities? ___ Sit ___ Walk ___ Stand ___ Kneel
 ___ Squat ___ Climb ___ Bend ___ Twist

 ___ Reach ___ Crawl ___ Push ___ Pull
 ___ Keyboard ___ Type ___ Mouse ___ Write

Leave Blank If It Doesn't Apply. ___ Finger ___ Grasp
 ___ Work Overhead

If Done Continuously, Circle. ___ Flex/Twist/Side-Bend/Extend Your Neck

(Job Description – continued)

Please List Your Job Duties/Activities At Work: (WHEN YOU WERE INJURED)

- A) _____
- B) _____
- C) _____
- D) _____
- E) _____
- F) _____
- G) _____

What Type Of Surface(s) Do You Work On? _____

Are You Required To **Lift At Work?** ___ YES ___ NO If 'YES', Please Answer The Following:

	<u>Objects Lifted</u>	<u>Weight In Pounds</u>	<u>Times Per Day</u>	<u>Distance Carried/Feet</u>
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____
3)	_____	_____	_____	_____
4)	_____	_____	_____	_____
5)	_____	_____	_____	_____

What Is the Heaviest Weight That You Are Required To Lift At Work? _____ Pounds

Do You Have To Bend Over Or Lean Forward While Lifting? ___ YES ___ NO

Are You Able To Lift The Same Amount Of Weight Now, As Before The Injury? ___ YES ___ NO

If 'NO', Please Explain What You Could Lift Before And What You Can Lift Now: _____

Does Your Job Require You To Reach Below, Above Or At Shoulder Level? ___ YES ___ NO

If 'YES', Please Explain: _____

Are You Required To Move Your Feet In A Repetitive Movement/Activity? ___ YES ___ NO

If 'YES', Please Describe: _____

Are You Required To Use Your Hands For Fine Manipulation, Grasping, Pushing, Pulling, Torquing?

___ YES ___ NO If 'YES', Please Describe: _____

(Job Description – continued)

Are You Exposed To Dust, Gas, Fumes, Vapors, Noise, Or Extreme Temperatures Or Humidity?

YES NO If 'YES', Please Explain: _____

Are You Required To Work At Heights Or Walk On Uneven Ground? YES NO If 'YES', Please Describe: _____

Are You Required to Drive Vehicles Or Work Near Hazardous Equipment? YES NO

If 'YES', Please Describe: _____

Do You Have Any Special Seeing/Visual Or Hearing Requirements? YES NO If 'YES',

Please Describe: _____

Are You Able To Perform Your Normal *Work Duties*? YES NO **If 'NO', Please Explain**

What Activities You Can't Do, Or Have Difficulty Performing: _____

WORK HISTORY:

Did You Have **More Than One Employer When You Were Injured?** YES NO

If 'YES', Please List The Employer(s), And The Activities Required At That Employment?

If 'YES', Did The Other Employment/Activities Listed Above Contribute To, Or Further Worsen

Your Condition? YES NO **If 'YES', Please Explain How?** _____

(Work History – continued)

Please List All Of **Your Previous Employers:** (i.e., Where You Have Worked Before The Job, Where Your Current Injury Occurred)

	<u>Employer</u>	<u>Dates Of Employment</u>	<u>Job Title/Duties</u>
A)	_____	_____	_____
B)	_____	_____	_____
C)	_____	_____	_____
D)	_____	_____	_____
E)	_____	_____	_____
F)	_____	_____	_____
G)	_____	_____	_____

Are You Still Working For The *Same Employer* Where Your Work Injury Occurred? ___ YES ___ NO
If 'NO', Answer The Questions Below. **If 'YES',** Skip The Following Questions And Go To The Next Section Entitled '**PAST MEDICAL HISTORY.**'

Why Aren't You Working For The Same Employer Now? _____

When Did You Stop Working For The Same Employer? _____

If You Are Not Working For The Same Employer As When You Were Injured, **Please List Your Employment Since Leaving:** ___ I Have Not Worked Since Leaving That Employment

	<u>Employer</u>	<u>Dates Of Employment</u>	<u>Job Title/Duties</u>
A)	_____	_____	_____
B)	_____	_____	_____
C)	_____	_____	_____
D)	_____	_____	_____
E)	_____	_____	_____
F)	_____	_____	_____
G)	_____	_____	_____

Who Is Your **Current Employer(s)**? _____

Are You Doing The Same Type Of Work? ___ YES ___ NO

If 'NO', Describe The Type Of Work You Are Doing Now, Including Details On Physical Activity:

(Work History - continued)

Has Any **NEW** Job Or Employment **Contributed To, Or Further Worsened Your Condition?**

YES NO If 'YES', Please Name The Employer(s) And Explain How?

Are You Going To Be **Retrained For Another Job/Occupation** As A Result Of This Work Injury?

YES NO I DO NOT KNOW RECOMMENDED Please Describe:

PAST MEDICAL HISTORY:

Please List **The Information About Your Medical History** In The Sections Below, With The **Approximate Dates**. If A Section Does Not Apply To You, Simply Mark An **(X)** In The 'Denied' Box:

Childhood Illnesses: () Denied _____

Childhood Injuries: () Denied _____

Allergies: () Denied _____

Present Medications Taken (Prescription & Over-The-Counter): () Denied _____

Surgeries: () Denied _____

Hospitalizations: () Denied _____

Adult Illnesses: () Denied _____

Doctor(s) Seen Previous To Your Current Work Injury: Name & Location/City: () Denied _____

FAMILY HISTORY:

List Any Health Problems In **Your Immediate Family**: (Mother, Father, Brother, Sister) () Denied

REVIEW OF SYSTEMS:

Please List Any Problems That You **Now Have** With The Following Body Systems:

Ears/Nose/Throat: () Denied _____
Eyes: () Denied _____
Lungs: () Denied _____
Liver: () Denied _____
G-I Tract (Stomach, Intestines, Bowels, Etc.): () Denied _____
Kidney/Bladder: () Denied _____
[Women] Reproductive System: () Denied _____
Skin: () Denied _____
Neurological: () Denied _____
Heart/Circulation: () Denied _____
Psychological: () Denied _____

OFF WORK ACTIVITIES:

Do You Exercise? ___ YES ___ NO If 'YES', Please Describe Type & Frequency. If 'NO', Please Explain Why You Don't: _____

Do You Participate In Any Sports Activities? ___ YES ___ NO If 'YES', Please Describe Type & Frequency: _____

Do You Have Any Hobbies? ___ YES ___ NO If 'YES', Please Describe Type & Frequency: _____

Are You Able To Perform Your Normal/Regular Household Chores/Activities? ___ YES ___ NO If 'NO', Please Explain What You Cannot Do & Why: _____

SOCIAL HISTORY:

Are You? () Married () Single () Separated () Divorced () Widowed

How Many Years Of Schooling Have You Had? _____

List Degrees, Diplomas, Licenses, Certifications You Hold: _____

Do You Use Alcohol? ___ YES ___ NO If 'YES', How Many Drinks Per Week? _____

Do You Use Tobacco? ___ YES ___ NO If 'YES', What Kind & Times Per Day Or Week? _____

Do You Use Drugs? ___ YES ___ NO If 'YES', What Kind & How Many Times Per Day Or Week? _____

List Any Other Habits, Describing Their Type & Frequency: _____

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE!

Injured Worker's Signature: _____ **Date:** _____

PHYSICIAN USE ONLY

ADDITIONAL HEADINGS/ISSUES

PHYSICAL EXAMINATION FINDINGS

DIAGNOSTIC TESTING

DIAGNOSIS

DISCUSSION

PERMANENT AND STATIONARY STATUS

CAUSATION

VOCATIONAL REHABILITATION

SUBJECTIVE FACTORS OF DISABILITY

OBJECTIVE FACTORS/FINDINGS OF DISABILITY

WORK PRECLUSIONS

APPORTIONMENT

FUTURE MEDICAL CARE

REASONS FOR OPINIONS

TEMPORARY TOTAL DISABILITY

COMPLIANCE STATEMENT

“I personally evaluated this patient and prepared this report. If others have performed any services in connection to this report, outside of clerical preparation, their name and qualifications are noted herein. The time spent was in accordance with (IMC) Industrial Medical Council guidelines. I declare under of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provide to me and, except as noted herein, that I believe to be true. I have not violated Labor Code Section 139.3 and the contents of this report and bill is true and correct to the best of my knowledge. This statement is made under penalty of perjury.”

If the report is billed as an **ML 101** or an **ML 104**, you will need to give an explanation as to why it qualifies (*please refer to the complexity factors in the Billing section*). You also need to detail the **time spent in**: **A.** reviewing the records **B.** face-to-face time with the patient **C.** preparation of the report **D.** other relevant activities detailed in the report.

Signed in _____ County, CA by:

PHYSICIAN'S ORIGINAL SIGNATURE

DATE

Cc

Attachments: For **State QMEs**, Attach **IMC** Form **111** & **DEU** Forms **100** & **101**