

Robert W. Poston, Ph.D., Q.M.E.
WORKERS COMP. EVAL QUESTIONNAIRE

EMPLOYEE INFORMATION

Name : _____ SSN : _____

DOB/ Age : _____

Address : _____

Phone No. : (main) _____ (other) _____

Male __ Female __ Right Handed __ Left Handed __ Both __ Height ____ Weight ____

EMPLOYER INFORMATION

Name of Business : _____

Address : _____ Phone # : _____

WORKER'S COMPENSATION INSURANCE CARRIER INFORMATION :

Name : _____ Phone # : _____

Address : _____

Claim Representative : _____ Fax # : _____

Defense Attorney: _____ Phone: _____

Law Office of: _____

Claim # : _____

ATTORNEY INFORMATION : () CHECK IF NONE

Law Office of : _____

Attorney's Name : _____

Address : _____ Ph. _____

Fax. _____

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) : _____

HISTORY OF THE INJURY

Please briefly describe how your work injury occurred :

Please briefly describe the symptoms arising from your injury :

How did your symptoms come on? ___ Suddenly ___ Gradually , If gradually, over what period of time? _____

When did you 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 : _____

Were you admitted to the hospital? ___ Yes ___ No, If 'Yes', how long? _____

Name Of Doctor(s) at the hospital who treated you? _____

Describe the type of treatment, diagnosis or 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?

(History Of Treatment - Continued)

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/specialty): _____

Describe treatment and/or tests: _____

What did the 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 #2 : _____ City/Location: _____

Type of doctor (degree/specialty): _____

Describe treatment and/or tests: _____

What did the 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:

(History Of Treatment - Continued)

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/specialty): _____

Describe treatment and/or tests: _____

What did the 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 results were? (use back
page if necessary): _____

Do you treat yourself? ___ Yes ___ No. If 'Yes', Please explain how : _____

(History Of Treatment - Continued)

Are you currently taking medication to relieve the effects of the injury?

___ Yes ___ No. If 'Yes', please describe what you take, (prescription or non-prescription), how much it helps, how often you take it, etc. : _____

Have there been any recommendation for diagnostic testing or treatment that you have not received? ___ Yes ___ No. 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 : _____

Have you ever had a **PRIOR** work injury(ies)? ___ Yes ___ No. If 'Yes', please explain:

Have you ever received a **PRIOR** worker's compensation disability award?

___ Yes ___ No. If 'Yes', please explain: _____

Have you ever served in the **Military**? ___ Yes ___ No. If 'yes', Did you receive a medical discharge? ___ Yes ___ No. If 'Yes', please explain why? _____

(History Of Other Injuries - Continued)

Have you ever had any **PRIOR, NON-WORK RELATED PSYCHIATRIC CONDITIONS?**

___ Yes ___ No. If 'Yes', please explain: _____

CURRENT SYMPTOMS

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

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

Complaint #3 : _____

What percentage of the time do you experience/feel this symptom? _____%

What activities make this symptom worse? _____

(Current Symptoms - Continued)

What makes this symptom better? _____

Can/do you have this symptom without activity? _____

Pain Scale : _____ 0 - 10

Complaint #4 : _____

What percentage of the time do you experience/feel this symptom? _____ %

What activities make this symptom worse? _____

What Make This Symptom Better? _____

Can/do you have this symptom without activity? _____

Pain Scale : _____ 0 - 10

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 ___ Poor,

If 'Fair' or 'Poor', please explain: _____

(Continued next page)

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 many rests breaks do you get in a normal work shift? _____

What percent of your work day do you work indoors? _____% outside _____%

Please List Your Job Duties/Activities At Work (AT THE TIME YOU WERE INJURED):

A). _____

B). _____

C). _____

D). _____

E). _____

F). _____

G). _____

Are you exposed to dust, gas, fumes, vapors, noise, or extreme temperature or humidity? ____

Yes ____ No. If 'Yes', please explain : _____

Do you have any special visual/hearing or other requirements? ____ Yes ____ No If 'Yes', please describe: _____

WORK HISTORY

Do you have **More Than One Employer At The Time You Were Injured?**

____ Yes ____ No. If 'Yes', please list the employer(s), and the activities 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>Date Of Employment</u>	<u>Job Title</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'**, Please Answer The Questions Below. **If 'Yes'** , please skip the following questions and go to the next section entitled '**MEDICAL HISTORY**'.

Why aren't you working for the same employer now? _____

When did you stop working for the same employer? Date: _____

If you are not working for the same employer as when you were injured, **Please List Your Employment Since Leaving**: or _____ I have not worked since leaving that employment.

	<u>Employer</u>	<u>Date Of Employment</u>	<u>Job Title</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', please 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:

MEDICAL HISTORY

Please list information about your medical history in the section 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 _____

FAMILY MEDICAL HISTORY

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

Denied _____

(continued next page)

REVIEW OF SYSTEMS

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

Ear/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 _____

OFF WORK ACTIVITIES

Do You Exercise? ___ Yes ___ No. **If 'Yes'** , please describe type and frequency. **If 'No'** , please explain why you don't : _____

Do you participate in any sport activities? ___ Yes ___ No. If 'Yes', please describe type and frequency: _____

Do you have any hobbies? ___ Yes ___ No. If 'Yes', Please describe type and frequency: _____

Are you able to perform your normal/regular household chores/activities? ___ Yes ___ No. If 'No", please explain what you can not do and why? _____

SOCIAL HISTORY

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

Prior marriages? Yes___, No ___, If "Yes", dates:_____.

How many years of education do you have? _____

List degrees, diplomas, licenses, certifications you hold: _____

Do you use alcohol? ___ Yes ___ No If ' Yes', how many drinks per week? _____

(Social History – Continued)

Do you use tobacco? ___ Yes ___ No. If 'Yes', what kind & times per day or week?

Do you use illicit drugs? ___ Yes ___ No. If 'Yes', what kind & how many times per day or per week? _____

Thank You For Your Time Completing This Questionnaire.

Please Sign Below.

Injured Worker's Signature: _____ Date: _____