Carol W. Fetterman, Ph.D., Q.M.E.

WORKERS COMP. EVAL QUESTIONAIRE

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) ay 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', lease 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)

	Employer	**Date Of Employment**	**Job Title**
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.

	Employer	**Date Of Employment**	**Job Title**
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: _____