Experience. Excellence.

WEBSTER ORTHOPEDICS
INDUSTRIAL INJURY PATIENT QUESTIONNAIRE

Please complete this questionnaire as fully as possible.

NAME OF PATIENT: ______________________ DATE OF EXAM: __________

DATE OF BIRTH: ______________________ SS# ______________________

CURRENT AGE: ________

YOUR STREET ADDRESS ______________________________________

CITY ______________________ STATE ______ ZIP ____________

PHONE# HOME __________ WORK __________ MOBILE ______________

HEIGHT ______________ WEIGHT ________________

☐ RIGHT HANDED ☐ LEFT HANDED ☐ AMBIDEXTROUS

HISTORY OF INJURY AND TREATMENT

DATE OF INJURY: ________________

PART OF BODY INJURED: ______________

HOW DID THE INJURY OCCUR? ______________________________________

____

DESCRIBE ALL THE MEDICAL CARE YOU HAVE RECEIVED FOR THIS INJURY: ______

____

____

ARE YOU PRESENTLY WORKING? ☐ YES ☐ NO

IF YOU ARE PRESENTLY WORKING, WHAT ARE YOUR JOB MODIFICATIONS?

____

____

HISTORY OF INJURY AND TREATMENT (CONT.)

DID YOU MISS ANY TIME FROM WORK FOLLOWING THIS INJURY? ☐ YES ☐ NO
IF YES, WHAT WERE THE DATES?

____

CHIEF COMPLAINTS AND CURRENT COMPLAINTS

PLEASE DESCRIBE YOUR CURRENT SYMPTOMS IN YOUR OWN WORDS: ______________

____

PLEASE DESCRIBE ANY ACTIVITIES WHICH MAKE YOUR SYMPTOMS WORSE: __________

____

PLEASE DESCRIBE ANY OTHER ACTIVITIES THAT YOU USED TO DO, BUT ARE NOT ABLE TO DO AT THE PRESENT TIME DUE TO YOUR CONDITION:

____

____

PAST INJURY HISTORY

HAVE YOU EVER BEEN INJURED ON THE JOB? ☐ YES ☐ NO

HAVE YOU EVER BEEN INJURED IN RECREATIONAL ACTIVITIES? ☐ YES ☐ NO

HAVE YOU EVER HAD ANY OTHER TYPE OF INJURY? ☐ YES ☐ NO

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE DESCRIBE BELOW:

____

____

____

MEDICAL HISTORY (CONT.)

ALLERGIES: ____________________

CIGARETTE USE: ____________ HOW MANY PER DAY? ____________

ALCOHOL USE: ____________ HOW MUCH PER DAY? ____________

OTHER DRUGS: ____________________

CURRENT PHYSICIAN: ____________________

FAMILY PHYSICIAN: ____________________

CHIROPRACTOR: ____________________

RELEVANT FAMILY HISTORY:

DOES ANYONE IN YOUR FAMILY HAVE SIMILAR MEDICAL PROBLEMS? ☐ YES ☐ NO

IF YES PLEASE DESCRIBE: ____________________

REVIEW OF SYSTEMS:

CHECK THE SYMPTOMS YOU HAVE HAD WITHIN THE PAST SIX MONTHS:

FREQUENT OR SEVERE HEADACHES ☐

DISORDERS OF VISION ☐

EXCESSIVE RINGING IN EARS ☐

LOSS OF HEARING ☐

CHEST PAIN ☐

PERSISTENT SORE THROAT ☐

STOMACH OR ABDOMINAL PAIN ☐

SHORTNESS OF BREATH ☐

BLOOD IN URINE ☐

BURNING WITH URINATION ☐

BLOOD IN BOWEL MOVEMENTS ☐

COUGHING UP BLOOD ☐

PAINS THAT GO FROM JOINT TO JOINT ☐

UNEXPLAINED WEIGHT LOSS ☐

MENSTRUAL DISORDERS ☐

PREGNANCY ☐

ARE YOU SEEING A DOCTOR FOR ANY OF THE ABOVE? ☐ YES NO ☐

IF YES, PLEASE PROVIDE PHYSICIAN'S NAME ____________________

IF NO, WHY HAVEN'T YOU SEEN A DOCTOR? ____________________

THE PURPOSE OF THIS EXAMINATION IS TO REPORT ON YOUR CURRENT CONDITION AS IT RELATES TO YOUR INJURIES.

JOB DESCRIPTION WHEN HIRED BY EMPLOYER

WHAT WAS YOUR JOB TITLE AT THE TIME YOU WERE INURED? ____________________

PLEASE DESCRIBE YOUR JOB DUTIES: ____________________

____

PLEASE DESCRIBE YOUR JOB'S PHYSICAL ACTIVITIES: ____________________

____

IF YOU LIFT, WHAT DO YOU LIFT, HOW FREQUENTLY AND HOW MUCH DOES IT WEIGH?

____

IF THERE IS ANY REACHING, WHAT DO YOU REACH FOR? ____________________

____

IF YOU KNEEL, TWIST, SQUAT OR CRAWL, HOW FREQUENTLY AND FOR WHAT PURPOSE?

____

ARE YOU STILL WORKING FOR THIS EMPLOYER? ____________________

WHAT IS YOUR CURRENT JOB TITLE? ____________________

PLEASE DESCRIBE YOUR CURRENT JOB'S ACTUAL DUTIES: ____________________

____

PLEASE DESCRIBE YOUR CURRENT JOB'S PHYSICAL ACTIVITIES: ____________________

____

MEDICAL HISTORY

CHILDHOOD ILLNESSES: ____________________

CHILDHOOD INJURIES: ____________________

ADULT ILLNESSES: ____________________

ARTHRITIS: ____________________

SURGERIES / HOSPITALIZATIONS: ____________________

____

____

CURRENT MEDICATIONS: ____________________ REASON TAKEN ____________________

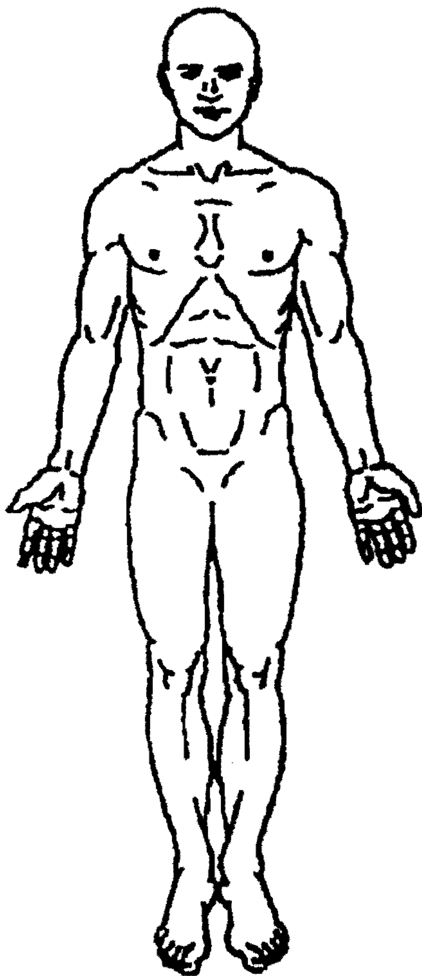
____________________ ____________________

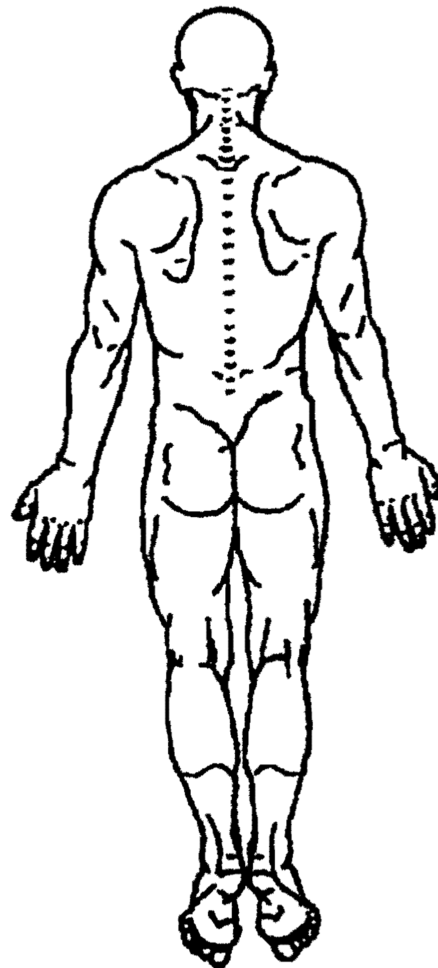
____________________ ____________________

Name ______________________ **Date** ______________________

PLEASE MARK WITH AN X WHERE YOU ARE EXPERIENCING PAIN

WHOLE BODY SYMPTOM DESCRIPTION





PLEASE CIRCLE YOUR PAIN LEVEL

LEAST 0 1 2 3 4 5 6 7 8 9 10 WORST