OCCUPATIONAL INJURY OR ILLNESS QUESTIONNAIRE

Patient Name____ Date of Birth______________________

Employer (at time of injury)_________________________________ Date of Injury_______________

Type of Business_________________________ Your Occupation______________ Date of Hire______

Last Date Worked_____________ Are you working now?_______________ Full Duty or Limited_____

Describe any time missed and or limitations you have been working with.________________________

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Accident Reported to Employer?_______ Name of person reported to__________________________

Type of work being done at time of injury____

Have you been treated by another Dr. for this injury? (**If no proceed to Medical Information**)

If yes, Name and address of Doctor____

Did you receive:

Medications ( )Yes ( )No **If Yes**, ( )Helped ( ) Worsened ( ) Unchanged

Physical Therapy ( )Yes ( )No **If Yes**, ( )Helped ( ) Worsened ( ) Unchanged

Other Tests (Xray, MRI, Nerve Conduction Studies) ( )Yes ( ) No What type?___________

Have you had any previous work comp injuries? ( ) Yes ( ) No

If yes, please list date of injury, body part and Insurance Carrier

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Please detail any other details of accident that are not noted or missing above.

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The above is an accurate account of my worker's comp injury as detailed.

_______________________________________ _______________________

Patient Signature **Date**

MEDICAL HISTORY

Have you had:

Complaint Similar to what you are having today?	( ) Yes	( ) No
Was that similar complaint due to an accident?	( ) Yes	( ) No
Any previous Motor Vehicle Accidents?	( ) Yes	( ) No
Other serious accidents requiring medical care?	( ) Yes	( ) No
Any serious illness(s)?	( ) Yes	( ) No
Any surgeries?	( ) Yes	( ) No
Any hospitalizations?	( ) Yes	( ) No
Any nervous or mental illness?	( ) Yes	( ) No
Any psychiatric care?	( ) Yes	( ) No
Medical Discharge from the Armed Forces?	( ) Yes	( ) No
Back injury?	( ) Yes	( ) No
Heart Problems?	( ) Yes	( ) No
Lung Problems?	( ) Yes	( ) No

If yes to any of the above, please describe details below including type of injury or illness, onset date(s), duration of illness, any other pertinent details:

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CURRENT MEDICAL COMPLAINTS

I currently have or have had since my injury, pain or discomfort in my.... **(Check all that are applicable as of right now)**

( ) Low back	( ) Mid Back	( ) Upper Back	( ) Neck
( ) Left Shoulder	( ) Right Shoulder	( ) Left Arm	( ) Right Arm
( ) Left Wrist	( ) Right Wrist	( ) Left Hand	( ) Right Hand
( ) Left Leg	( ) Right Leg	( ) Left Knee	( ) Right Knee
( ) Left Foot	( ) Right Foot	( ) Lower Abdomen	( ) Upper Abdomen
( ) Buttocks	( ) Groin	( ) Vagina	( ) Other ____________

My pain began ( ) Gradually ( ) Suddenly

I have pain ( ) Sometimes ( ) All The Time

I have ( ) Numbness ( ) Tingling in my ______________________________

My pain is worse when I:

( ) Cough	( ) Sneeze	( ) Sit	( ) Bend	( ) Walk	( ) Lift
( ) Push	( ) Pull	( ) Type	( ) Have Sexual Activity		( ) Lay Down

My pain wakes me during the night. ( ) Yes ( ) No

Changes in the weather affect my pain ( ) Yes ( ) No

Please list any further pertinent details regarding your current or past medical history not mentioned or noted above:

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The above is an accurate account of my current and past medical condition. I authorize Monterey Bay Urgent Care / Cypress Urgent Care to release medical information pertaining to the date of injury stated above to the Employer stated above and to the Workman's Compensation Insurance Carrier for named Employer at the time of injury. You may revoke this authorization in writing at any time.

______________________________ ______________________

Patient Signature Date

JOB DESCRIPTION

In a typical 8 hour workday, I **(Circle number of hours in each activity)**

Sit:	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk:	1	2	3	4	5	6	7	8	hours

On the job I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
In an 8 hr day	0%	33%	34%-66%	67%-100%
Bend/Stoop	( )	( )	( )	( )
Squat	( )	( )	( )	( )
Crawl	( )	( )	( )	( )
Climb	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Kneel	( )	( )	( )	( )
Lift (Note Lbs)	( )______lbs	( )______ lbs	( )______ lbs	( )______ lbs
Balancing	( )	( )	( )	( )
Pushing / Pulling	( )	( )	( )	( )
Reach above Shoulder level	( )	( )	( )	( )

Do you:

Bend over while doing lifting?	( ) Yes	( ) No
Use your feet for repetitive movements such as operating foot controls?	( ) Yes	( ) No
Use your hands for repetitive actions?	( ) Yes	( ) No
Use your hands for simple grasping?	( ) Yes	( ) No
Use your hands for firm grasping?	( ) Yes	( ) No
Use your hands for fine manipulation?	( ) Yes	( ) No
Required to work no unprotected heights?	( ) Yes	( ) No
Required to be around moving machinery?	( ) Yes	( ) No
Exposed to marked changes in temperature and humidity?	( ) Yes	( ) No
Required to drive automotive equipment?	( ) Yes	( ) No
Exposed to dust, fumes, and/or gases?	( ) Yes	( ) No

If yes to any of the above, please describe details of activity.

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List any additional activities not listed or noted above.

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The above is an accurate depiction of my job description and all duties included with my employment as of the undersigned date.

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Patient Signature — Date