JOB DESCRIPTION

IN TERMS OF AN 8-HOUR WORKDAY, "OCCASIONALLY " MEANS 33%, "FREQUENTLY" MEANS 34% TO 66%, AND "CONTINUOUSLY" MEANS 67% TO 100% OF THE DAY.

IN A TYPICAL 8-HOUR WORKDAY, I (CIRCLE THE NUMBER OF HOURS OF 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
BEND/STOOP	❑	❑	❑	❑
SQUAT	❑	❑	❑	❑
CRAWL	❑	❑	❑	❑
CLIMB	❑	❑	❑	❑
REACH ABOVE SHOULDER LEVEL	❑	❑	❑	❑
CROUCH	❑	❑	❑	❑
KNEEL	❑	❑	❑	❑
BALANCING	❑	❑	❑	❑
PULLING/PUSHING	❑	❑	❑	❑

ON THE JOB, I LIFT:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
UP TO 10 POUNDS	❑	❑	❑	❑
11 TO 24 POUNDS	❑	❑	❑	❑
25 TO 34 POUNDS	❑	❑	❑	❑
35 TO 50 POUNDS	❑	❑	❑	❑
51 TO 74 POUNDS	❑	❑	❑	❑
75 TO 100 POUNDS	❑	❑	❑	❑

❑ YES ❑ NO DO YOU HAVE TO BEND OVER WHILE DOING ANY LIFTING?

❑ YES ❑ NO ARE YOUR FEET USED IN REPETITIVE MOVEMENTS, SUCH AS OPERATING FOOT CONTROLS?

DO YOU USE YOUR HANDS FOR REPETITIVE ACTIONS SUCH AS:

	SIMPLE GRASPING		FIRM GRASPING		FINE MANIPULATING	
RIGHT HAND	❑ YES	❑ NO	❑ YES	❑ NO	❑ YES	❑ NO
LEFT HAND	❑ YES	❑ NO	❑ YES	❑ NO	❑ YES	❑ NO

❑ YES ❑ NO ARE YOU REQUIRED TO WORK AT UNPROTECTED HEIGHTS? IF YES, DESCRIBE: _____

❑ YES ❑ NO ARE YOU REQUIRED TO BE AROUND MOVING MACHINERY? IF YES, DESCRIBE: _____

❑ YES ❑ NO ARE YOU EXPOSED TO MARKED CHANGES IN TEMPERATURE AND HUMIDITY? IF YES, DESCRIBE: _____

❑ YES ❑ NO ARE YOU REQUIRED TO DRIVE AUTOMOTIVE EQUIPMENT? IF YES, DESCRIBE: _____

❑ YES ❑ NO ARE YOU EXPOSED TO DUST, FUMES, AND/OR GASES? IF YES, DESCRIBE: _____

❑ YES ❑ NO PLEASE LIST ANY ADDITIONAL COMMENTS: _____

SIGNATURE: _____ DATE: _____

WORKER'S COMPENSATION – PATIENT HISTORY

PLEASE PRINT:

NAME: _____ DATE: _____

EMPLOYER'S BUSINESS NAME AT TIME OF ACCIDENT: _____

EMPLOYER'S PHONE: _____ EMPLOYER'S ADDRESS: _____

OCCUPATION: _____

❑ YES ❑ NO PREVIOUS WORKER'S COMPENSATION INJURY? IMPAIRMENT RATING: _____

LENGTH OF TIME AT THIS JOB PRIOR TO INJURY: _____

DATE OF INJURY: _____ TIME OF INJURY: _____ LAST DATE WORKED: _____

WHAT WERE YOU DOING AT THE TIME YOU WERE INJURED? HOW DID THE ACCIDENT/INJURY HAPPEN? (LIFTING, BENDING, WALKING, CARRYING, STANDING, ETC.) _____

WHEN DID THE PAIN BEGIN? WHERE DID YOU FIRST FEEL IT? WAS THE PAIN INTENSE AT FIRST OR DID IT GRADUALLY WORSEN? PLEASE BE SPECIFIC: _____

_____

REPORT ACCIDENT/ACCIDENT OBSERVER

WHAT DATE DID YOU REPORT THIS INJURY ON? _____

WHO DID YOU REPORT THIS INJURY TO? _____

WHAT IS HIS/HER POSITION? _____

❑ YES ❑ NO DID ANYONE OBSERVE THIS ACCIDENT/INJURY?

IF YES, NAME: _____

POSITION: _____

SYMPTOMS FROM ACCIDENT

❑ YES ❑ NO DID YOU RECEIVE BLEEDING CUTS OR BRUISES? IF CUTS, WHERE? _____

IF BRUISES, WHERE? _____

PLEASE DESCRIBE HOW YOU FELT. PLEASE BE SPECIFIC.

IMMEDIATELY AFTER THE ACCIDENT: _____

LATER THAT ❑ DAY ❑ NIGHT: _____

THE NEXT DAY(S): _____

_____

CHECK SYMPTOMS THAT HAVE BECOME APPARENT SINCE THE ACCIDENT/INJURY:

1. ❑ NERVOUSNESS
2. ❑ NECK PAIN/STIFFNESS
3. ❑ MIDBACK PAIN
4. ❑ LOW BACK PAIN
5. ❑ EYES SENSITIVE TO LIGHT
6. ❑ PAIN BEHIND EYES
7. ❑ DIZZINESS
8. ❑ COLD SWEATS
9. ❑ FACE FLUSHED
10. ❑ RINGING/BUZZING EARS
11. ❑ LOSS OF BALANCE
12. ❑ LOSS OF SMELL
13. ❑ LOSS OF TASTE
14. ❑ LOSS OF MEMORY
15. ❑ PINS & NEEDLES - ARMS
16. ❑ PINS & NEEDLES - LEGS
17. ❑ SHORTNESS OF BREATH
18. ❑ HEAD SEEMS TOO HEAVY
19. ❑ IRRITABILITY
20. ❑ DEPRESSION
21. ❑ SLEEPING TROUBLE
22. ❑ TOE NUMBNESS
23. ❑ FINGER NUMBNESS
24. ❑ COLD HANDS
25. ❑ COLD FEET
26. ❑ CHEST PAIN
27. ❑ CONSTIPATION
28. ❑ DIARRHEA
29. ❑ FATIGUE
30. ❑ TENSION
31. ❑ FEVER
32. ❑ HEADACHE
33. ❑ FAINTING
34. ❑ ANXIETY
35. ❑ SEIZURES
36. ❑ VISUAL DISTURBANCES
37. ❑ FORGETFULNESS
38. ❑ BLURRED VISION
39. ❑ DOUBLE VISION
40. ❑ CONFUSED
41. ❑ DISORIENTED
42. ❑ OTHER _____

MECHANISM OF INJURY

PLEASE EXPLAIN THE MECHANISM OF THE INJURY (ONLY FILL IN THOSE SECTIONS THAT APPLY TO YOU):

FALL:

A) ❑ YES ❑ NO DID YOU HIT ANYTHING WHEN YOU FELL? IF YES, WHAT? _____

B) ❑ YES ❑ NO WERE YOU CARRYING ANYTHING WHEN YOU FELL? IF YES, WHAT? _____

HOW MUCH DID IT WEIGH? _____ LBS.

C) ❑ YES ❑ NO DID YOU TWIST WHEN YOU FELL? IF SO, TO WHICH SIDE? ❑ LEFT ❑ RIGHT

❑ YES ❑ NO DID IT LAND ON YOU? IF YES, WHERE? _____

D) ❑ YES ❑ NO WAS THE AREA LIGHTED?

E) DESCRIBE THE CONDITION OF THE AREA (SLIPPERY, GRAVELED, ETC.) _____

F) WHAT PART OF THE BODY DID YOU FALL ON? _____

G) HOW FAR DID YOU FALL? (FT.) _____

H) WHAT DID YOU LAND ON? _____

LIFT/PULL:

A) How much did the object weigh? _____ lbs.

B) ❑ Yes ❑ No Did you fall after the injury? If yes, how far? _____

❑ Yes ❑ No Did you hit anything when you fell? What? _____

C) ❑ Yes ❑ No Were you twisting when you were lifting/pulling? If yes, to which side? ❑ Left ❑ Right

D) How far off the ground did you have the object before the pain started? _____

E) ❑ Yes ❑ No Did you drop the object when the pain started?

❑ Yes ❑ No Did it land on you? Where? _____

F) Did you lift with your ❑ Legs ❑ Back ❑ Other _____

BEND:

A) ❑ Yes ❑ No Were you lifting when you were bent over? If yes, how much did the object weigh? _____ lbs.

B) How far were you bent over? _____

C) ❑ Yes ❑ No Did you fall when the pain started? How far? _____

D) ❑ Yes ❑ No Were you twisting when you bent forward? Toward which side? ❑ Left ❑ Right

E) ❑ Yes ❑ No Did you land on anything? If so, what _____

WORK STATUS HISTORY

❑ Yes ❑ No Have you lost time from work as a result of this new injury?

If yes, dates: _____

❑ Yes ❑ No Have you gone back to work? When: _____

If yes, what status of work: ❑ Modified ❑ regular

List restrictions you have been placed on: _____

If you have gone back to work, list activities that are:

Painful: _____

Difficult: _____

❑ Yes ❑ No If you are currently on disability (time loss), do you want to go back to work doing your regular job?

If no, why not? _____

❑ Yes ❑ No Are there any problems you have with a fellow employee, supervisor, or manager that needs to be discussed? If yes, explain: _____

FIRST DOCTOR/HOSPITAL/CLINIC

❑ Yes ❑ No Were you hospitalized as a result of this accident? If yes, where: _____

Doctor 1 Name: _____ Date of first visit: _____

❑ Yes ❑ No Were you examined? ❑ Yes ❑ No Were X-rays taken?

What diagnosis did the doctor give you? _____

❑ Yes ❑ No Were you given treatment? If yes, what type? _____

What benefits did you receive from this treatment? _____

Date of last treatment: _____

❑ Yes ❑ No Did the doctor refer you to another health professional? If yes, to whom and for what? _____

❑ Yes ❑ No Did you follow the doctor's recommendation? If no, why not? _____

SECOND DOCTOR/CLINIC

Doctor 2 Name: _____ Date of first visit: _____

❑ Yes ❑ No Were you examined? ❑ Yes ❑ No Were X-rays taken?

❑ Yes ❑ No Were you given treatment? If yes, what type? _____

What benefits did you receive from this treatment? _____

Date of last treatment: _____

PRIOR SIMILAR SYMPTOMS

❑ Yes ❑ No Did you have any physical complaints just before the accident? If yes, please describe in detail: _____

❑ Yes ❑ No Have you ever had any prior injuries, accidents, diseases or treatment to the area of your body now affected?

If yes, what part was previously injured? _____

Date hurt: _____ Describe injury: _____

❑ Yes ❑ No Were you treated? By whom? _____

Date treatment began: _____ Ended: _____

The last date you felt pain or problems from that injury: _____