ACUPUNCTURE CONTINUUM

WORKERS' COMPENSATION PATIENT QUESTIONNAIRE

Today's Date____________

INJURED WORKER/EMPLOYEE INFORMATION

Name:____ Age________

Birthdate________________________

Address:____

Phone No.______________________ Social Security#_______________________

Height________________ Weight________________

Are you right handed or left handed? ____________________ Eye Color__________ Hair Color _________

Do you wear corrective lenses?___________

Are you currently working at the employment in which you were injured?___________________

If yes, are you currently working in the same position in which you were employed before your work injury?

____

If not, what position do you currently work in?___________________________

What is your weekly gross salary?______________________

What is your weekly net salary?_______________________

INSURANCE INFORMATION

Name of Workers' Compensation Insurance Carrier:____

Address of Insurance Carrier:____

Telephone Number:_____________________________ Claim No.:_______________

Claims Representative:_________________________________

WORK INJURY INFORMATION

Employer Name at the time of the injury:____

Address of Employer:____

Telephone #:________________________

When did you start working for this employer?______________

Are you still working for this employer?____________

If so, are you still working in the same job that you had at the time of the injury?__________ If not, please list your current position:____________________________

If you are at a different company, what is the name of the company and the position you currently hold:____

Date of Injury:___________ Time of Injury:__________a.m./p.m.

Date you reported your injury to your employer? ____________________

317 N. El Camino Real, Suite 401 Encinitas, CA 92024
P: 760-635-0581 F: 760-635-0587

Person you reported your injury to:________________________________

Location where you were injured:

____

Do you have a Workers' Comp attorney?_____________

If yes, please give name, address and telephone number:____

____

HISTORY OF THE INJURY

Please describe in your own words how your work injury incurred:____

____

____

____

____

____

When did you realize you were injured?

____

Did your symptoms come on suddenly?_________ Or did they come on gradually?________ If gradually, over what period of time?_____________________

What area/s of your body were injured in this work injury? ____

____

Please describe your injuries :____

____

____

____

HISTORY OF TREATMENT

IMMEDIATELY AFTER THE INJURY, did you go to a Hospital or Emergency Room?____________

If so, when (date, time):________________

Name and Address of Hospital: ____

Name of Physician/s Seen:____

What type of treatment were you given?____

What was their diagnosis? ____

Did they recommend any work restrictions or any change in your work activities? _______________

If so, please list:____

Were you told you needed further treatment?__________________

If so, what was recommended or who were you referred to?______________________________

When did you first seek medical care after your injury? ______________________________

Did your employer send you for treatment?_________ Or did you seek treatment on your own? ____________

Below, please list all of the healthcare providers you have seen regarding this work injury. Please list them in order of seeing them (if there are more than space is provided, please attach a separate sheet of paper and continue listing them)

PHYSICIAN/FACILITY #1

Name of Physician:____

Telephone Number:_________________

Type of Physician:_______________________________________

What was the diagnosis:___________________

Were you told you needed more treatment? If so, please explain:

____

Date of First Appointment:___________________

Date Treatment Ended: _____________________

How many times did you see this physician? ___________ How long were your treatments? ___________

What was/were the results of the treatment/s?

____

Did your condition improve with these treatments?

____

Are you still being treated by this physician?________________ If so, how often?____________________

Did this physician prescribe you take off work?___________ If yes, what dates?_______________________

Did this physician restrict or modify your work activities?__________ If yes, please describe:_____________

____

Did this physician refer you to another physician or healthcare practitioner?_______

If so, please list the physician, the physician's address and the reason for the referral:

____

____

PHYSICIAN/FACILITY#2

Name of Physician:____

Telephone Number:_________________

Type of Physician:_______________________________________

What was the diagnosis:___________________

Were you told you needed more treatment? If so, please explain:

____

Date of First Appointment:___________________

Date Treatment Ended: _____________________

How many times did you see this physician? ___________ How long were your treatments? ___________

What was/were the results of the treatment/s?

____

Did your condition improve with these treatments?

____

Are you still being treated by this physician?________________ If so, how often?____________________

Did this physician prescribe you take off work?___________ If yes, what dates?_______________________

Did this physician restrict or modify your work activities?__________ If yes, please describe:_____________

____

Did this physician refer you to another physician or healthcare practitioner?________

If so, please list the physician, the physician's address and the reason for the referral:

____

____

PHYSICIAN/FACILITY #3

Name of Physician:____

Telephone Number:__________________

Type of Physician:____

What was the diagnosis:____________________

Were you told you needed more treatment? If so, please explain:

____

Date of First Appointment:___________________

Date Treatment Ended: ______________________

How many times did you see this physician? ____________ How long were your treatments? ____________

What was/were the results of the treatment/s?

____

Did your condition improve with these treatments?

____

Are you still being treated by this physician?_________________ If so, how often?____________________

Did this physician prescribe you take off work?___________ If yes, what dates?______________________

Did this physician restrict or modify your work activities?__________ If yes, please describe:____________

____

Did this physician refer you to another physician or healthcare practitioner?________

If so, please list the physician, the physician's address and the reason for the referral:

____

____

PHYSICIAN/FACILITY #4

Name of Physician:____

Telephone Number:__________________

Type of Physician:____

What was the diagnosis:____________________

Were you told you needed more treatment? If so, please explain:

____

Date of First Appointment:___________________

Date Treatment Ended: ______________________

How many times did you see this physician? ____________ How long were your treatments? ____________

What was/were the results of the treatment/s?

____

Did your condition improve with these treatments?

____

Are you still being treated by this physician?_________________ If so, how often?____________________

Did this physician prescribe you take off work?___________ If yes, what dates?______________________

Did this physician restrict or modify your work activities?__________ If yes, please describe:____________

____

Did this physician refer you to another physician or healthcare practitioner?________

If so, please list the physician, the physician's address and the reason for the referral:

____

____

PHYSICIAN/FACILITY #5

Name of Physician:____

Telephone Number:____________________

Type of Physician:____

What was the diagnosis:_______________________

Were you told you needed more treatment? If so, please explain:

____

Date of First Appointment:______________________

Date Treatment Ended: _________________________

How many times did you see this physician? ______________ How long were your treatments? ______________

What was/were the results of the treatment/s?

____

Did your condition improve with these treatments?

____

Are you still being treated by this physician?___________________ If so, how often?_______________________

Did this physician prescribe you take off work?_____________ If yes, what dates?___________________________

Did this physician restrict or modify your work activities?____________ If yes, please describe:_______________

____

Did this physician refer you to another physician or healthcare practitioner?________

If so, please list the physician, the physician's address and the reason for the referral:

____

____

PHYSICIAN/FACILITY #6

Name of Physician:____

Telephone Number:____________________

Type of Physician:____

What was the diagnosis:_______________________

Were you told you needed more treatment? If so, please explain:

____

Date of First Appointment:______________________

Date Treatment Ended: _________________________

How many times did you see this physician? ______________ How long were your treatments? ______________

What was/were the results of the treatment/s?

____

Did your condition improve with these treatments?

____

Are you still being treated by this physician?___________________ If so, how often?_______________________

Did this physician prescribe you take off work?_____________ If yes, what dates?___________________________

Did this physician restrict or modify your work activities?____________ If yes, please describe:_______________

____

Did this physician refer you to another physician or healthcare practitioner?________
If so, please list the physician, the physician's address and the reason for the referral:

____

____

CURRENT HISTORY

Please list any other treatment, testing, examinations or therapy you have received which is not listed above (please include name, address and telephone number)?

____

____

List all medications you are currently on and what they are for:

____

____

____

Have you been prescribed any brace, support, cane, walker, wheelchair, TENS unit, crutches or other aid because of the effects of this injury?_________
If yes, please describe: ____

____

What treatment has been has worked the best and has given you the longest lasting results?

____

Please describe the results:

____

____

Were there any recommendations for diagnostic imaging (x-ray, CT scan, MRI, etc.) that you have not received? If so, what was recommended and by whom?

____

____

HISTORY OF OTHER INJURIES

Have you ever experienced any of the same symptoms before this work injury? ______________________
If yes, please explain:

____

____

Please list all prior work injuries? (List date, describe injury.)

____

____

____

Have you previously served in the Military? ____________

If yes, did you receive a medical discharge? __________________

If yes, please explain why:

____

____

Please list any prior, non-work related injuries (i.e., sprain/strains, auto accidents, falls, etc.). Please include date of injury, type of injury and when/if the injury was resolved:

____

____

____

____

Do you have any NEW injuries involving body parts which are a part of your current work injury?

____

If so, please list:

____

____

____

Have you noticed any new symptoms which you attribute to this work injury?

____

____

CURRENT COMPLAINTS

Please list each of the symptoms your experience **WHICH WERE CAUSED FROM THIS WORK INJURY**, and rate each symptom according to the pain scale below:

PAIN SCALE

0-1	Minimal	The pain is an annoyance but does not stop me from working.
2-3	Slight	I can tolerate the pain but it causes some difficulty in doing my work. However, it does not stop me from working.
5	Moderate	The pain causes a marked handicap in my ability to work, but I can continue.
7-8	Moderate to Severe	The pain is approaching the worst I have ever experienced or could imagine. It causes a significant problem with working and most of the time I cannot work.
10	Severe	The pain is the worst I have ever experienced or could imagine and causes me to stop all work and activity.

Symptom #1:_______________________________ Pain Rating:______

Do you experience: Numbness and Tingling?___________ Tenderness?_____________ Burning?___________ Radiating?_____________

What percentage of the of time do you experience this symptom?______________ What percentage of time do you experience this symptom at your place of employment?________________

What activities make it worse?

____

____

What work activities make this symptom worse?

____

What makes this symptom improve?

____

Symptom #2:_______________________________ Pain Rating:______

Do you experience: Numbness and Tingling?___________ Tenderness?_____________ Burning?___________ Radiating?_____________

What percentage of the of time do you experience this symptom?______________ What percentage of time do you experience this symptom at your place of employment?________________

What activities make it worse?

____

____

What work activities make this symptom worse?

____

What makes this symptom improve?

____

Symptom #3:_______________________________ Pain Rating:______

Do you experience: Numbness and Tingling?___________ Tenderness?_____________ Burning?___________ Radiating?_____________

What percentage of the of time do you experience this symptom?______________ What percentage of time do you experience this symptom at your place of employment?________________

What activities make it worse?

____

____

What work activities make this symptom worse?

____

What makes this symptom improve?

____

Symptom #4:__________________________________ Pain Rating:______

Do you experience: Numbness and Tingling?___________ Tenderness?_____________ Burning?___________ Radiating?_____________

What percentage of the of time do you experience this symptom?______________ What percentage of time do you experience this symptom at your place of employment?_________________

What activities make it worse?

____

____

What work activities make this symptom worse?

____

What makes this symptom improve?

____

Symptom #5:__________________________________ Pain Rating:_______

Do you experience: Numbness and Tingling?___________ Tenderness?_____________ Burning?___________

Radiating?_____________

What percentage of the of time do you experience this symptom?______________ What percentage of time do you experience this symptom at your place of employment?_________________

What activities make it worse?

____

____

What work activities make this symptom worse?

____

What makes this symptom improve?

____

Has your condition improved, worsened or stayed the same in the last two months? ________

Please explain:

____

____

Do you think your condition will improve over time?_______________

Please explain: ____

____

____

Please describe your health before your work injury? (Circle one) Excellent Good Fair Poor

If fair or poor, please explain:

____

____

JOB DESCRIPTION

What was your job title at the time of your injury:

____

Please describe your job and its duties:

____

How many hours per day do you normally work? ____

How many days per week (and which days):____

How long is your lunch break?______________

How long are your breaks and how often do you get them? ________________________________

Please list the percentage of your day that you work indoors? _____________________________

What percentage do you work outdoors? ____

Please list how many hours per day you do these activities? If done continuously, please circle:

_____	Sitting	_____	Climbing
_____	Standing	_____	Crawling
_____	Walking	_____	Typing
_____	Running	_____	Grasping
_____	Lifting	_____	Bending
_____	Squatting	_____	Pushing
_____	Reaching	_____	Using Mouse
_____	Keyboard	_____	Kneeling
_____	Using finger/s	_____	Twisting
_____	Working overhead	_____	Pulling
_____	Bending you neck forward, backward, sideways or turning your neck	_____	Writing

Please list your job duties as of the date of your injury:

(a) ____

(b) ____

(c) ____

(d) ____

(e) ____

(f) ____

Please describe the type of surface you work on:

____

Does your job require lifting? __________ If yes, please fill out the following:

	Objects Lifted	Weight in Pounds	Times Per Day	Distance Carried/Feet
(a)	________	_________	________	____________

(b) ___________ _____________ ___________ _________________

(c) ___________ _____________ ___________ _________________

(d) ___________ _____________ ___________ _________________

(e) ___________ _____________ ___________ _________________

Are you able to lift the same amount of weight that you were able to lift prior to the injury? ___________

If no, please list how much you are able to lift now? ____________________

Does your job require you to work overhead or below or at shoulder level? _________

If yes, please explain:____

Are you required to move your feet repetitively in any activity? ___________

If yes, please explain: ____

____

Are you required to use your hands for fine manipulation, grasping, pulling, pushing? _______

If yes, please explain: ____

____

Are you exposed to dust, gas, fumes, vapors, noise or extreme temperatures or humidity? _______

If yes, please explain: ____

____

____

Are you required to work at heights or walk on uneven ground? ___________

If yes, please explain:

____

____

Are you required to drive vehicles or work near hazardous equipment? ___________

If yes, please explain:

____

____

Do you have any special visual or hearing requirements? ___________

If yes, please

explain:____

____

Are you able to perform your normal work duties? ___________

If no, please explain which activities you cannot do or have difficulty doing:

____

____

____

WORK HISTORY

Did you have more than one employer at the time of your injury? ___________

If yes, please list the employer/s and the activities required at that employment:

____

____

____

If you answered yes, did any of these activities contribute to or further worsen your condition? __________

If yes, please explain how:

____

____

____

Please list all of your previous employers (where you worked BEFORE the job where you were injured):

	Employer	Dates of Employment	Job Title and Duties
(a)	____________________	_______________	_______________________________________
(b)	____________________	_______________	_______________________________________
(c)	____________________	_______________	_______________________________________
(d)	____________________	_______________	_______________________________________
(e)	____________________	_______________	_______________________________________
(f)	____________________	_______________	_______________________________________

Are you still working for the employer you had at the time of your work injury? ____________

If not, please answer the following questions:

(a) Why are you not working for that employer?

____

____

(b) Please list the name of your new employer?

____

(c) Are you doing the same type of work?

____

(d) Please describe your work duties at your new employment:

____

____

If you are not working at the same employment, please list all employers you have had since the work injury:

	Employer	Dates of Employment	Job Title and Duties
(a)	____________________	_______________	_______________________________________
(b)	____________________	_______________	_______________________________________

(c) ____________________ ______________ ______________________________________

(d) ____________________ ______________ ______________________________________

(e) ____________________ ______________ ______________________________________

(f) ____________________ ______________ ______________________________________

Has any new employment contributed to or worsened your condition? _________

If yes, please name the employer and explain how:

____

____

Are you going to be retrained for another job as a result of this work injury? ________

If yes, please describe:

____

____

____

PAST MEDICAL HISTORY

Please list any childhood illnesses you have had and the approximate dates:

____

____

Please list any childhood injuries you had and the approximate dates:

____

____

____

Do you have any allergies? If so, please list:

____

____

Please list any previous surgeries you have had and the dates:

____

____

____

Were you ever hospitalized? If so, when and for what reason?

____

____

____

Please list any adult illnesses you have had the approximate date:

____

____

Please name all doctors you have seen previous to this work injury:

	Doctor Name	Address/Phone Number	Reason
(a)	____________	________________	________________
		________________	________________
			________________
(b)	____________	________________	________________
		________________	________________
			________________
(c)	____________	________________	________________
		________________	________________
			________________
(d)	____________	________________	________________
		________________	________________
			________________
(e)	____________	________________	________________
		________________	________________
			________________

FAMILY HISTORY

Please list any health problems in your immediate family (father, mother, sister, brother):

Health Problem	Which Family Member
______________	__________
______________	__________
______________	__________
______________	__________
______________	__________

REVIEW OF BODY SYSTEMS

Please list any problems that you now have with the following body systems:

Eyes ____
Ears/Nose/Throat ____
Heart ____
Lungs ____
Liver ____
Intestines ____
Stomach ____
Kidney ____
Bladder ____
Skin ____
Female Reproductive System ______________________________________
Males – Prostate Problems ______________________________________
Neurological: ____
Psychological: ____

OFF-WORK ACTIVITIES

Do you exercise? ____________________________

If yes, please describe the type and frequency. If you do not exercise, please explain why not.

____

____

What kind of physical activities do you participate in?

____

How often?

____

Has this work injury limited these activities? ____

If so, please explain how:

____

____

Are you able to perform your normal daily activities (housework, chores, activities)? ____________________

If no, please explain what you are unable to do and why?

____

____

SOCIAL HISTORY

Please circle the one which applies: Married Single Separated Divorced Widowed

How many years of education have you had?

____

Please list your degrees, diplomas, licenses and/or certifications you have:

____

____

Do you drink alcohol? ________ If so, how many drinks per week? _______________ Do you smoke? ________

If so, how many cigarettes per day do you smoke? __________________

Do you use recreational drugs? ____________

If so, please list the name/s and how many times per day or week?

____

Do you have any other habits?

____

If so, please list the habit and how often?

____

Thank you for taking the time to complete this questionnaire.

Dated:_________________________ ____

Injured Worker's Signature