



# 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? \_\_\_\_\_

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,<br>backward, sideways or<br>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:

<u>Objects Lifted</u>	<u>Weight in Pounds</u>	<u>Times Per Day</u>	<u>Distance Carried/Feet</u>
-----------------------	-------------------------	----------------------	------------------------------

(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):

	<u>Employer</u>	<u>Dates of Employment</u>	<u>Job Title and Duties</u>
(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:

	<u>Employer</u>	<u>Dates of Employment</u>	<u>Job Title and Duties</u>
(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:

	<u>Doctor Name</u>	<u>Address/Phone Number</u>	<u>Reason</u>
(a)	_____	_____ _____	_____ _____ _____
(b)	_____	_____ _____	_____ _____ _____
(c)	_____	_____ _____	_____ _____ _____
(d)	_____	_____ _____	_____ _____ _____
(e)	_____	_____ _____	_____ _____ _____

**FAMILY HISTORY**

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

<u>Health Problem</u>	<u>Which Family Member</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

## 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**