THE HETRICK CENTER

You have a choice for Physical Therapy…choose us!

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Worker's Compensation History

Patient Name: _____

Date of Birth: ____/____/____ Date of Accident/Injury: ____/____/____

Instructions: Please complete this form to the best of your ability. Please fill-in your answers on the line or circle the appropriate answer.

1. Name of employer at time of accident: _____
2. Length of time worked there prior to accident: _____
3. Type of work being done at time of injury: _____
4. In your own words, please describe accident:
5. Have you been treated by another doctor for this accident? Yes No
   If yes, please list Doctor's name and address: _____
   What type of treatment did you receive? _____
   How long were you treated by this Doctor? _____
6. Are you: Improved Unchanged Don't know
7. What medications are you currently taking? (List name and dosage)

   Do these medications help? Yes No Don't know
8. Have you had Physical Therapy? Yes No
   If yes, how often? (circle one)
   Daily Every other day Several times a week Weekly
   Every other week Monthly Other: _____
   Did Physical Therapy help? Yes No Don't know
9. Prior to this accident, have you ever had any physical complaints similar to what you have now? Yes No Don't know
   If yes, please describe. _____
10. Were these similar complaints due to a previous accident(s)? Yes No
11. Have you had any other serious accidents which required medical care? Yes No
    If yes, please describe. _____

12. Have you had any serious illnesses that required hospitalization? Yes No
    If yes, please describe. _____
    _____
13. Have you had any surgeries? Yes No
    If yes, please list date and type. _____
    _____
14. Have you had any nervous or mental illness? Yes No
15. Have you had psychiatric care? Yes No
16. Have you received a medical discharge from the Armed Services? Yes No
17. Have you returned to work since this accident? Yes No
18. If you have returned to work, please fill out the information below.

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY or REGULAR DUTY	FULL TIME or PART TIME

CURRENT MEDICAL COMPLAINTS

BACK PAIN:

1. Currently, I have pain in my: low back mid back upper back
2. My pain began: gradually suddenly
3. I have pain: sometimes all of the time
4. My pain goes into my: right leg left leg both
5. I have tingling and/or numbness in: right leg left leg both
6. My pain is worse when I: (Circle all that apply)

Cough or Sneeze	Walk	Pull
Sit	Lift	
Bend	Push	

7. My back is worse with sexual activity. Yes No
8. My pain wakes me up during the night. Yes No
9. Changes in the weather affect my pain. Yes No

NECK PAIN:

1. My neck pain began: gradually suddenly
2. I have pain: sometimes all of the time
3. My pain goes into my: right arm left arm both
4. I have tingling and/or numbness in: right arm left arm both
5. My pain is worse when I: (Circle all that apply)

Cough or Sneeze	Push
Bend Forward	Pull
Lift	Turn my head

6. My pain wakes me up during the night. Yes No
7. Changes in the weather affect my pain. Yes No
8. I have neck stiffness. Yes No
9. I have headaches. Yes No

If I do get headaches, they occur: Sometimes All of the time

OTHER PAIN:

Please describe any current medical complaints which you are experiencing that have not been covered on the questionnaire or list any additional comments you wish to make regarding your condition.

_____

_____

_____

_____

JOB DESCRIPTION

In terms of an 8-hour workday, "occasionally" means 33%, "frequently" means 34-66% and "continuously" means 67-100% of the workday.

1. In a typical 8 hour workday, I: (Circle # of hours per activity)

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

2. On the job, I perform the following activities:

	Not at all	Occasionally	Frequently	Continuously
Bend/Stoop	□	□	□	□
Squat	□	□	□	□
Crawl	□	□	□	□
Climb	□	□	□	□
Reach above Shoulder height	□	□	□	□
Crouch	□	□	□	□
Kneel	□	□	□	□
Balancing	□	□	□	□
Pushing/Pulling	□	□	□	□

3. On the job, I lift:

	Not at all	Occasionally	Frequently	Continuously
Up to 10 pounds	□	□	□	□
11-24 pounds	□	□	□	□
25-34 pounds	□	□	□	□
35-50 pounds	□	□	□	□
51-74 pounds	□	□	□	□
75-100 pounds	□	□	□	□

4. Do you have to bend over while doing any lifting? Yes No
5. Are your feet used for repetitive movements, such as operating foot controls? Yes No

6. 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

7. Are you required to work on unprotected heights? Yes No
   If yes, please describe. _____
8. Are you required to work around moving machinery? Yes No
   If yes, please describe. _____
9. Are you exposed to marked changes in temperature and humidity? Yes No
   If yes, please describe. _____
10. Are you required to drive automotive equipment? Yes No
    If yes, please describe. _____
11. Are you exposed to dust, fumes or gas? Yes No
    If yes, please describe. _____
12. Please list any additional comments you may have.

_____

_____

_____

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____