The Hetrick Center
Work Injury Questionnaire

Patient Name: _____ **Patient DOB:** _____

Date of Work Accident/Injury: _____

Instructions: Please complete this form to the best of your ability. Please fill in your answers on the line provided or circle/check the appropriate answer where indicated. Thank you.

Employer Information

Name of Employer: _____

Length of time worked there prior to accident/injury: _____

Type of work being done at the time of accident/injury :_____

_____

In your own words, please describe the accident/injury: _____

_____

_____

Medical Treatment for this Injury

Have you been treated by another doctor/medical professional for this accident/injury? 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? _____

Are you (*circle*): Improved Unchanged Don't Know

Medications

What medications are you currently taking (name and dosage)?: _____

_____

Do these medications help? (*circle*) Yes No Don't Know

Physical Therapy

Have you had physician therapy for this accident/injury? Yes ___ No ___

If yes, how often? (*circle*) Daily Every other day Several times per week Weekly Every other week Monthly Other: _____

Did physical therapy help? (*circle*) Yes No Don't Know

Previous Accident/Injury

Prior to this accident/injury, have you ever had any physical complaints similar to what you have now? (*circle*) Yes No Don't Know

If yes, please describe: _____

_____

If yes, were these similar complaints due to a previous accident(s)? Yes ___ No ___

Have you had any other serious accidents which required medical care? Yes ___ No ___

If yes, please describe: _____

_____

Past Medical History

Have you had any serious illnesses that required hospitalization? Yes ___ No ___
If yes, please describe: _____
_____

Have you had any surgeries? Yes ___ No ___
If yes, please list date and type of surgery: _____
_____

Have you ever had any nervous or mental illness? Yes ___ No ___
Have you had psychiatric care? Yes ___ No ___
Have you received a medical discharged from the Armed Forces? Yes ___ No ___
Have you returned to work since this accident/injury? Yes ___ No ___
If yes, please fill out the information below:

DATE	*EMPLOYER*	*OCCUPATION*	*LIGHT DUTY OR REGULAR DUTY*	*FULL-TIME OR PART-TIME*

Current Medical Complaints

Back Pain (*circle answers)*

Currently, I have pain in my: Lower back Mid-back Upper back
My pain began: Gradually Suddenly
I have pain: Sometimes All of the time
My pain goes into my: Left leg Right leg Both legs N/A
I have tingling and/or numbness in: Left leg Right leg Both legs N/A
My pain is worse when I: (*circle all that apply*)
Cough or sneeze Walk Push Pull
Sit Lift Bend
My back pain is worse with sexual activity: Yes No
My pain wakes me up during the night: Yes No
Changes in the weather affect my pain: Yes No

Neck Pain (circle answers)

My neck pain began: Gradually Suddenly
I have pain: Sometimes All of the time
My pain goes into my: Left arm Right arm Both arms N/A
I have tingling and/or numbness in: Left arm Right arm Both arms N/A
My pain is worse when I: (*circle all that apply*)
Cough or sneeze Lift Push Pull
Turn my head Bend
My pain wakes me up during the night: Yes No
Changes in the weather affect my pain: Yes No
I have neck stiffness: Yes No
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 1-33% of the workday, "frequently" means 34-66% of the workday, and "continuously" means 67-100% of the workday. ***

In a typical 8-hour workday (circle the # 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

On the job, I perform the following activities: (check the appropriate answer)

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

On the job, I lift: (check the appropriate answer)

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

On the job, do you have to bend over while doing any lifting? Yes No
Are your feet used for repetitive movements, such as operating foot controls? Yes No
Do you use your hands for repetitive actions, such as:

	Simple Grasping	Firm Grasping	Fine Manipulation
Right Hand:	Yes / No	Yes / No	Yes / No
Left Hand:	Yes / No	Yes / No	Yes / No

Are you required to work on unprotected heights? Yes No
If yes, please describe: _____
Are you required to work around moving machinery? Yes No
If yes, please describe: _____
Are you exposed to marked changes in temperature and humidity? Yes No
If yes, please describe: _____
Are you required to drive automotive equipment? Yes No
If yes, please describe: _____
Are you exposed to dust, fumes and/or gas? Yes No
If yes, please describe: _____

Please list any additional comments that you may have:

_____
_____
_____

Patient's Printed Name: _____

Patient's Social Security Number: _____

Patient Signature _____ **Date** _____

THC Provider Signature _____ **Date** _____

▢ **Ed Bartakovits, DC**	▢ **Timothy Duke, DC**	▢ **Alexandra Marriggi Potter, DC**
▢ **Mary Colman, DC**	▢ **Charlene Hobbie, DC**	▢ **Allyson M. Bell PT, DPT**
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