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# WORK INJURY QUESTIONNAIRE

Patient Name: _____ Today's Date: _____

Date of Injury: _____ Time of Injury: _____: _____ ☐ AM ☐ PM

Location of Injury: _____

Describe how the injury happened: _____

_____

_____

Was any part of your body hit? ☐ No ☐ Yes: _____

Any cuts, bruises or abrasions? ☐ No ☐ Yes: _____

Hit your head or lose consciousness? ☐ No ☐ Yes: _____

Were the police summoned? ☐ No ☐ Yes Was an ambulance summoned? ☐ No ☐ Yes
Did you go to the hospital? ☐ No ☐ Yes Were x-rays taken? ☐ No ☐ Yes

Have you been examined and/or treated for your injuries? ☐ No ☐ Yes (please describe) :

_____

_____

**Circle all that apply:** Emergency room / X-rays / CT / MRI / Pain Medication / Muscle Relaxers / NSAIDS

How did you feel immediately after the injury? _____

_____

Could you move all parts of your body? ☐ Yes ☐ No: _____

Could you walk unaided? ☐ Yes ☐ No: _____

How did you feel **that night**? _____

_____

How did you feel over the **next few days**? _____

_____

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Check any symptoms that have occurred since the injury:

- ☐ headache ☐ neck pain/stiffness ☐ mid back pain ☐ low back pain
- ☐ dizziness ☐ numbness (arms/hands) ☐ shortness of breath ☐ numbness (legs/feet)
- ☐ fatigue ☐ sleeping problems ☐ nervous/anxious ☐ tension
- ☐ Other: _____

Have you missed time for work? ☐ No ☐ Yes : missed full time work: from _____ to _____

missed part time work: from _____ to _____

Are your work activities restricted as a result of this injury? ☐ No ☐ Yes: _____

_____

Did you have any physical complaints just before the injury? ☐ No ☐ Yes: _____

_____

Check any symptoms that you had ***BEFORE*** the injury:

- ☐ headache ☐ neck pain/stiffness ☐ mid back pain ☐ low back pain
- ☐ dizziness ☐ numbness (arms/hands) ☐ shortness of breath ☐ numbness (legs/feet)
- ☐ fatigue ☐ sleeping problems ☐ nervous/anxious ☐ tension
- ☐ Other: _____

_____

Patient/Guardian Signature: _____ Date: _____