**WORK-RELATED INJURY QUESTIONNAIRE**

Name:_____ Date:_____

1. Date of Accident:_____
2. Name of employer at the time of accident:_____
3. Length of time worked there prior to accident:_____
4. Type of work being done at time of injury:_____
5. In your own words, please describe the accident_____
   _____
   _____
6. 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?_____
7. Are you: ( ) improved ( ) unchanged ( ) getting worse
8. What types of medications are you taking for this injury?_____

   Do these medications help? ( ) Yes ( ) No ( ) Don't know
9. Have you had physical therapy? ( ) Yes ( ) No
   If yes, how often?_____
10. Prior to this accident, have you ever had any of the physical complaints similar to what you have now?
    ( ) Yes ( ) No ( ) Don't know

    If yes, please describe:_____

    Were these similar complaints the results of a previous accident(s)? ( ) Yes ( ) No
    Please provide details of accident(s):_____
    _____
11. Have you returned to work ? ( ) Yes ( ) No