

Fitness for Duty/Return to Work Questionnaire

Date of Injury/Illness: _____ Employer Requesting Exam: _____ Job Title: _____

1. Please describe your injury/illness: _____

2. Have you received any health care for this injury/illness? Yes No

If yes, when and where?

Primary Provider's Office: _____

Emergency Department: _____

Specialty Care: _____

Chiropractic Care: _____

Physical or Hand Therapy: _____

Imaging (X-Ray, CT, MRI, EMG): _____

Surgery: _____

Other: _____

3. Is the injury/illness related to work? Yes No To be determined

4. Have you been off work for this injury/illness? Yes No If yes, for how long? _____

5. Has a health care provider cleared you to return to work?

Yes, with no restrictions

Yes, with the following restrictions: _____

No, unable to work due to: _____

6. Do you feel you are ready to return to work?

Yes, with no restrictions

Yes, with the following restrictions: _____

No, unable to work due to: _____

7. List all current or past medical conditions: _____

8. List all surgeries: _____