

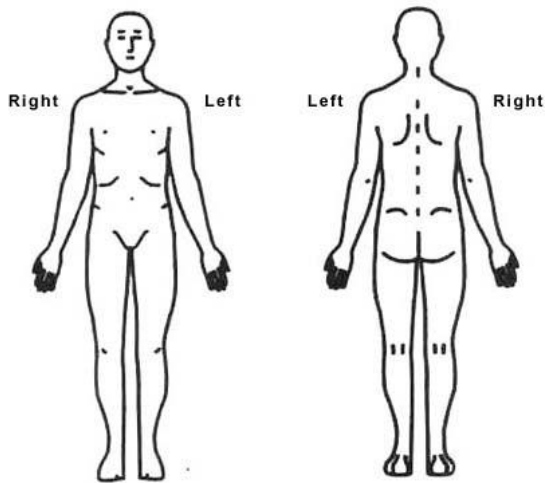
Initial Injury Questionnaire

Date of injury: _____ Employer at time of injury: _____ Job title at time of injury: _____

How long have you worked for this employer? _____ How long have you worked in this job before the injury? _____

Please describe how your injury occurred:

Please circle the areas where you have pain, aching, numbness, tingling, or burning.



Have you received any care for this injury? Yes No
If yes, when and where?

Have you had a similar injury in the past? Yes No
If yes, please describe:

Do you have any other jobs? Yes No
If yes, please describe:

List all hobbies:

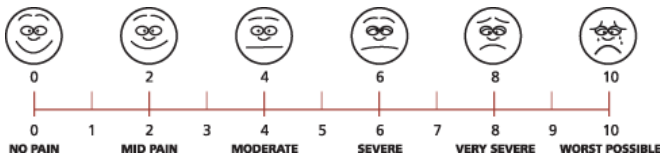
List all medical conditions (high blood pressure, diabetes):

List all medications that you take regularly:

List all allergies including allergies to medications:

List all surgeries or overnight stays in the hospital:

On the scale below, circle your current pain level.



Since the injury occurred, is your pain?

Better Same Worse

What makes the pain better?

What makes the pain worse?

Do you feel you need work restrictions? Yes No

If yes, which activities?

Have you used tobacco? Current Former Never

Do you drink alcohol? Current Former Never

If 100% is normal, what is your current function? _____%