WORKERS COMPENSATION - ACCIDENT QUESTIONNAIRE

Patient's Name:_____ Today's Date:_____

Date of Accident:_____ Time of Accident: ___:___ ___ a.m. p.m.

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND YOUR WORK RELATED ACCIDENT:

LIFTING INJURY

Weight Of Object Lifted:

_____ pounds (lbs.)

Position of Object Lifted:

❑Above Head ❑ At Ground Level ❑At Head Level ❑At Shoulder Level ❑At Waist Level ❑Below Waist Level

❑Other (please explain) _____

Your Position While Lifting:

❑Bending At Knees ❑Bending At Waist ❑Leaning Forward ❑Standing ❑Stretching On A Ladder

❑Other (please explain) _____

Type Of Pain After Injury:

❑ Achy ❑ Dull ❑ Gripping ❑ Sharp

❑Other (please explain) _____

FALLING ACCIDENT

Fell From Where?

❑Down Stairs ❑From 4 Feet ❑From 8 Feet ❑From A Ladder ❑ From Higher Than 8 Feet ❑ Onto Ground

❑Other (please explain) _____

What Body Parts Impacted Upon The Fall (please explain)?

_____

_____

Other Body Areas Effected (please explain)?

_____

_____

PLEASE FILL OUT ALL QUESTIONS ON THE NEXT PAGE THAT PERTAIN TO YOUR WORK RELATED INJURY

WORK COMP QUESTIONNAIRE (Continued)

IMMEDIATELY AFTER ACCIDENT PATIENT (YOU) FELT:

❑Dull Pain ❑Sharp Pain

❑Other (please explain) _____

WHERE DID YOU DEVELOP PAIN?

❑ Left Knee
❑ Left Shoulder
❑ Low Back
❑ Right Knee
❑ Right Shoulder
❑ Neck

❑Other (please explain) _____

OTHER INJURIES:

❑Twisted At Waist
❑Wrist Injury From Pulling
❑Wrist Injury From Pushing
❑Wrist Injury From Repetitive Motion

❑Other (please explain) _____

INDICATE AREAS OF LACERATIONS (CUTS):

❑Left Elbow ❑Left Knee ❑Left Forearm
❑Right Elbow ❑Right Knee ❑Right Forearm

❑Other (please explain) _____

ADDITIONAL SYMPTOMS:

TIME AFTER INJURY (When You Started Feeling Pain):

❑5 Minutes ❑Immediately ❑One Day ❑One Hour ❑Several Days

❑Other (please explain) _____

ADDITIONAL SYMPTOMS AFTER INJURY:

❑Headache ❑Low Back Ache

❑Other (please explain) _____

❑Other (please explain) _____

❑Other (please explain) _____

Did You loss Consciousness?❑yes ❑no

Did You Receive Emergency Care At The Scene Of The Accident?❑yes ❑no

WHERE DID YOU GO IMMEDIATELY AFTER THE INJURY?

❑Home ❑Walk In Emergency Clinic ❑To Continue With Your Schedule ❑To Hospital Emergency Room

❑To Work ❑Other (please explain) _____

PLEASE CONTINUE TO THE NEXT PAGE AND DESCRIBE YOUR WORK CONDITIONS

WORK COMP QUESTIONNAIRE (Continued)

REGULAR ACTIVITIES AT WORK:

❑Bending ❑Climbing ❑Crawling ❑Driving ❑Kneeling ❑Lifting ❑Pulling ❑Pushing
❑Reaching ❑Running ❑Sitting ❑Squatting ❑Kneeling ❑Standing ❑Walking

❑Other (please explain) _____

WEIGHT NORMALLY LIFTED AT WORK:

_____ pounds (lbs.)

HAND AND WRIST MOVEMENTS:

❑Left Hand Firmly Grasping ❑Right Hand Firmly Grasping
❑Left Hand Lightly Grasping ❑Right Hand Firmly Grasping
❑Typing ❑Using A Computer Mouse

❑Other (please explain) _____

TIME REQUIRED FOR OTHER WORK ACTIVITIES (HOURS):

Job Description **Duration (Hours Per Day)**

(please explain) _____

(please explain) _____

(please explain) _____

PLEASE DESCRIBE, IN DETAIL, ANY OTHER RELAVANT INFORMATION BELOW:

_____

_____

_____

_____

_____

_____ _____
Your Signature Date

Additional Note Area (Reserved For Attending Doctor):

_____

_____

_____

_____

REASON FOR REPORT CIRCLE ONE INITIAL PROGRESS FINAL	M-1 PRACTITIONER'S REPORT STATE OF MAINE WORKERS' COMPENSATION BOARD Office of Medical/Rehabilitation Services	TYPE OF PRACTITIONER CIRCLE ONE MD DO DC LIST OTHER _____

EMPLOYEE

EMPLOYER NAME:	EMPLOYEE LAST NAME:	FIRST NAME:	M.I.:
EMPLOYER MAILING ADDRESS & PHONE #:	ADDRESS - NUMBER AND STREET:		
INSURER NAME:	CITY:	STATE: ZIP:	HOME PHONE:
INSURER MAILING ADDRESS:	DATE OF INJURY:	SSN:	
PATIENT'S COMPLAINTS:			

PRACTITIONER

ICD-9 CODE: _____

IN MY OPINION, THIS PROBLEM IS ☐ WORK RELATED ☐ NOT WORK RELATED ☐ IS NOT YET IDENTIFIED AS TO CAUSE

HAVE DIAGNOSTIC TESTS BEEN PERFORMED? ☐ YES ☐ NO RESULTS: _____

_____

DATE OF THIS EXAMINATION : ___/___/___ IS TREATMENT TO CONTINUE? ☐ YES ☐ NO

DATE PATIENT TO BE SEEN AGAIN: ___/___/___ ESTIMATED LENGTH OF TREATMENT? _____

TREATMENT PLAN: _____

_____

LIST ANY MEDICATION PRESCRIBED FOR THIS DIAGNOSIS/CONDITION THAT WOULD PREVENT YOUR PATIENT FROM DRIVING AND/OR WORKING SAFELY: _____

_____

_____

IF UNABLE TO WORK, ADVISE ESTIMATED DATE OF RETURN : ___/___/___ P.I. RATING : ___/___/___

WORK CAPACITY: ☐ REGULAR DUTY ☐ MODIFIED DUTY ☐ NO WORK CAPACITY

RESTRICTIONS YES/NO	DESCRIBE:

IS PERMANENT IMPAIRMENT EXPECTED? ☐ YES ☐ NO

HAS MMI BEEN REACHED? ☐ YES ☐ NO

_____ _____

SIGNATURE OF PRACTITIONER PRINT NAME AND ADDRESS

TELEPHONE #: _____ NARRATIVES ATTACHED? ☐ YES ☐ NO