

WORK COMP QUESTIONNAIRE

Important: This form may be used in the determination of your Workers Compensation eligibility and the amount of compensation you are entitled. To protect your rights please fill out this form correctly and completely.

Name: _____

1. Date of Accident ____/____/____ 2. Time of Accident ____:____ AM PM

3. Name of Employer at time of Accident: _____

4. Employer Address: _____

5. City _____ State _____ Zip _____ Phone (____) _____

6. Occupation _____

7. In terms of an 8 hour workday: (Circle number of hours for each activity)

Sit (1 2 3 4 5 6 7 8) hours
Stand (1 2 3 4 5 6 7 8) hours
Walk (1 2 3 4 5 6 7 8) hours

8. On the job, I perform the following activities: (Circle as many as apply)

Bend/Stoop Squat Crawl Climb Reach above shoulders
Crouch Knee Push/Pull Maintain awkward posture

9. On the job, I regularly lift between:

A) 1 – 10 lbs) 11-24 lbs. C) 25-34 lbs. D) 35-50 lbs. E) 51-74 lbs. F) 75-100 lbs

10. Are you required to bend over while lifting? YES NO

11. Do you use your hands for repetitive movements such as (Circle as many as apply)

A) Simple Grasping (left hand) B) Firm Grasping (left hand) C) Fine Manipulating (left hand)
D) Simple Grasping (right hand) E) Firm Grasping (right hand) F) Fine Manipulating (right hand)

Prior to this accident were you experiencing any similar physical complaints? YES NO

If yes, please explain: _____

In your own words, please describe accident: _____

WORKERS COMP INFORMATION

TODAY'S DATE: _____

NAME: _____

DATE OF INJURY: _____

LENGTH OF EMPLOYMENT: _____

JOB TITLE: _____

JOB DESCRIPTION: _____

ANY PRIOR INJURIES OR CLAIMS? _____

ANY PRIOR, SIMILAR, OR MUSCULOSKELETAL PROBLEMS? _____

CURRENT WORK STATUS

REGULAR DUTY: _____

MODIFIED DUTY: _____

OFF WORK: _____ SINCE: _____