

# THE HETRICK CENTER

*You have a choice for Physical Therapy...choose us!*

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## Worker's Compensation History

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of Accident/Injury: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Instructions: Please complete this form to the best of your ability. Please fill-in your answers on the line or circle the appropriate answer.**

1. Name of employer at time of accident: \_\_\_\_\_
2. Length of time worked there prior to accident: \_\_\_\_\_
3. Type of work being done at time of injury: \_\_\_\_\_

4. In your own words, please describe accident:  
\_\_\_\_\_  
\_\_\_\_\_

5. 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? \_\_\_\_\_

How long were you treated by this Doctor? \_\_\_\_\_

6. Are you: Improved Unchanged Don't know  
7. What medications are you currently taking? (List name and dosage)

\_\_\_\_\_

Do these medications help? Yes No Don't know

8. Have you had Physical Therapy? Yes No  
If yes, how often? (circle one)

Daily Every other day Several times a week Weekly  
Every other week Monthly Other: \_\_\_\_\_

Did Physical Therapy help? Yes No Don't know

9. Prior to this accident, have you ever had any physical complaints similar to what you have now? Yes No Don't know  
If yes, please describe. \_\_\_\_\_

10. Were these similar complaints due to a previous accident(s)? Yes No

11. Have you had any other serious accidents which required medical care? Yes No  
If yes, please describe. \_\_\_\_\_

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Have you had any serious illnesses that required hospitalization?      Yes    No

If yes, please describe. \_\_\_\_\_

12. Have you had any surgeries?      Yes    No

If yes, please list date and type. \_\_\_\_\_

13. Have you had any nervous or mental illness?      Yes    No

14. Have you had psychiatric care?      Yes    No

15. Have you received a medical discharge from the Armed Services?      Yes    No

16. Have you returned to work since this accident?      Yes    No

17. If you have returned to work, please fill out the information below.

DATE	EMPLOYER	OCCUPATION	LIGHT DUTY or REGULAR DUTY	FULL TIME or PART TIME

### CURRENT MEDICAL COMPLAINTS

**BACK PAIN:**

1. Currently, I have pain in my:      low back      mid back      upper back
2. My pain began:      gradually      suddenly
3. I have pain:      sometimes      all of the time
4. My pain goes into my:      right leg      left leg      both
5. I have tingling and/or numbness in:      right leg      left leg      both
6. My pain is worse when I: (Circle all that apply)
 

Cough or Sneeze	Walk	Pull
Sit	Lift	
Bend	Push	
7. My back is worse with sexual activity.      Yes    No
8. My pain wakes me up during the night.      Yes    No
9. Changes in the weather affect my pain.      Yes    No

**NECK PAIN:**

1. My neck pain began:      gradually      suddenly
2. I have pain:      sometimes      all of the time
3. My pain goes into my:      right arm      left arm      both
4. I have tingling and/or numbness in:      right arm      left arm      both
5. My pain is worse when I: (Circle all that apply)
 

Cough or Sneeze	Push
Bend Forward	Pull
Lift	Turn my head

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- |   |           |                 |  |
|---|-----------|-----------------|--|
| 6. My pain wakes me up during the night.  | Yes       | No              |  |
| 7. Changes in the weather affect my pain. | Yes       | No              |  |
| 8. I have neck stiffness.                 | Yes       | No              |  |
| 9. I have headaches.                      | Yes       | No              |  |
| If I do get headaches, they occur:        | Sometimes | All of the time |  |

**OTHER PAIN:**

Please describe any current medical complaints which you are experiencing that have not been covered on the questionnaire or list any additional comments you wish to make regarding your condition.

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### JOB DESCRIPTION

**\*In terms of an 8-hour workday, “occasionally” means 33%, “frequently” means 34-66% and “continuously” means 67-100% of the workday.\***

1. In a typical 8 hour workday, I: (Circle # of hours per activity)

Sit:	1	2	3	4	5	6	7	8
Stand:	1	2	3	4	5	6	7	8
Walk:	1	2	3	4	5	6	7	8

2. On the job, I perform the following activities:

	<u>Not at all</u>	<u>Occasionally</u>	<u>Frequently</u>	<u>Continuously</u>
Bend/Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above Shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing/Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. On the job, I lift:

	<u>Not at all</u>	<u>Occasionally</u>	<u>Frequently</u>	<u>Continuously</u>
Up to 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-24 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25-34 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35-50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51-74 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
75-100 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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4. Do you have to bend over while doing any lifting? Yes    No  
5. Are your feet used for repetitive movements, such as operating foot controls? Yes    No  
6. Do you use your hands for repetitive actions, such as:

	<u>SIMPLE GRASPING</u>		<u>FIRM GRASPING</u>		<u>FINE MANIPULATING</u>	
Right hand:	Yes	No	Yes	No	Yes	No
Left hand:	Yes	No	Yes	No	Yes	No

7. Are you required to work on unprotected heights? Yes    No  
If yes, please describe. \_\_\_\_\_  
\_\_\_\_\_
8. Are you required to work around moving machinery? Yes    No  
If yes, please describe. \_\_\_\_\_  
\_\_\_\_\_
9. Are you exposed to marked changes in temperature and humidity? Yes    No  
If yes, please describe. \_\_\_\_\_  
\_\_\_\_\_
10. Are you required to drive automotive equipment? Yes    No  
If yes, please describe. \_\_\_\_\_  
\_\_\_\_\_
11. Are you exposed to dust, fumes or gas? Yes    No  
If yes, please describe. \_\_\_\_\_  
\_\_\_\_\_
12. Please list any additional comments you may have.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Printed Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_