Workers' Compensation Questionnaire

1. Was your accident directly related to your work? □ Yes □ No

2. Briefly describe the events that occurred just before and during your accident: _____

_____

_____

3. Did you report your accident to your employer? □ Yes □ No

4. Did your accident render you unconscious? □ Yes □ No

5. If yes, how long? _____

6. Please describe how you felt immediately after the accident: _____

_____

_____

7. Describe any treatment you received: _____

_____

_____

8. Were x-rays taken? □ Yes □ No

9. Was medication prescribed: □ Yes □ No

10. If yes, what type: _____

_____

11. Are your work activities restricted as a result of this injury: □ Yes □ No

12. Indicate the symptoms that are a result of this accident:

□	Dizziness	□	Headache	□	Neck Pain
□	Difficulty Sleeping	□	Fatigue	□	Stomache Upset/
□	Arms/Shoulder Pain	□	Chest Pain		Nausea
□	Upper/Mid Back Pain	□	Back Stiffness	□	Stiff Neck
□	Memory Loss	□	Blurred Vision	□	Jaw Problems
□	Irritability	□	Shortness of Breath	□	Tension
□	Numb Hands/Fingers	□	Numb Feet/Toes	□	Leg Pain
□	Lower Back Pain	□	Ears Ringing/Buzzing	□	Other:

13. Is your condition getting worse? □ Yes □ No